

**Appendix B: Sample Contract**



**OREGON HEALTH PLAN**

**HEALTH PLAN SERVICES CONTRACT**

**Coordinated Care Organization**

**Contract # xxxxxxxx**

**with**

**xxxxxxx**

## Table of Contents

I.	Effective Date and Duration .....	7
II.	Contract in its Entirety .....	8
III.	Vendor or Sub-Recipient Determination .....	8
IV.	Status of Contractor .....	9
V.	Enrollment Limits and Service Area.....	9
VI.	Interpretation and Administration of Contract.....	9
VII.	Contractor Data and Certification .....	11
VIII.	Signatures.....	13
	Exhibit A - Definitions.....	14
	Exhibit B –Statement of Work - Part 1 – Governance and Organizational Relationships .....	15
	1. Governing Board and Governance Structure .....	15
	2. Clinical Advisory Panel .....	15
	3. Innovator Agent and Learning Collaborative .....	15
	Exhibit B –Statement of Work - Part 2 – Covered and Non-Covered Services .....	16
	1. Covered Services .....	16
	2. Provision of Covered Service .....	16
	3. Authorization or Denial of Covered Services .....	18
	4. Covered Service Components.....	20
	5. Non-Covered Health Services with Care Coordination.....	31
	6. Non-Covered Health Services without Care Coordination.....	32
	Exhibit B –Statement of Work - Part 3 – Patient Rights and Responsibilities, Engagement and Choice.....	33
	1. Member and Member Representative Engagement and Activation .....	33
	2. Member Rights under Medicaid .....	33
	3. Provider’s Opinion.....	35
	4. Informational Materials and Education of Members and Potential Members .....	35
	5. Grievance System .....	37
	6. Enrollment and Disenrollment.....	37
	7. Identification Cards.....	42
	8. Marketing to Potential Members .....	42
	9. Member Communications.....	43
	Exhibit B –Statement of Work - Part 4 – Providers and Delivery System .....	44
	1. Integration and Coordination .....	44
	2. Access to Care.....	44
	3. Delivery System and Provider Capacity .....	47
	4. Provider Workforce Development.....	48
	5. Provider Selection.....	48
	6. Credentialing.....	49
	7. Patient Centered Primary Care Homes (PCPCH).....	51
	8. Care Coordination.....	53
	9. Care Integration .....	54
	10. Delivery System Dependencies .....	55
	11. Evidence-Based Clinical Practice Guidelines.....	56
	12. Health Promotion and Prevention.....	56
	13. Subcontract Requirements .....	57
	14. Minority-Owned, Woman-Owned and Emerging Small Business (“MWESB”) Participation. ....	60
	15. Adjustments in Service Area or Enrollment .....	60

Exhibit B –Statement of Work - Part 8 – Operations ..... 64

- 1. Accountability and Transparency of Operations ..... 64
- 2. Privacy, Security and Retention of Records ..... 65
- 4. Payment Procedures ..... 66
- 5. Claims Payment ..... 67
- 6. Medicare Payers and Providers ..... 69
- 7. Eligibility Verification for Fully Dual Eligible Members ..... 69
- 8. All Payers All Claims (APAC) Reporting Program ..... 70
- 9. Administrative Performance Program ..... 70
- 10. Encounter Claims Data ..... 71
- 12. Encounter Claims Data (Non-Pharmacy) ..... 73
- 13. Encounter Pharmacy Data ..... 73
- 14. Drug Rebate Program ..... 74
- 16. Third Party Liability and Personal Injury Liens ..... 75
- 18. Disclosure of Ownership Interest ..... 78
- 19. Upon renewal or extension of the Contract ..... 79
- 20. Subrogation ..... 80
- 21. Contractor’s Board of Directors ..... 80

Exhibit B –Statement of Work - Part 9 – Program Integrity ..... 81

- 1. Monitoring and Compliance Review ..... 81
- 2. Conditions that may Result in Sanctions ..... 81
- 3. Range of Sanctions Available ..... 83
- 4. Corrective Action Plan ..... 84
- 5. Liquidated Damages ..... 85
- 6. Intermediate Sanctions ..... 86
- 7. Sanction Process ..... 87
- 8. Notice to CMS of Contractor Sanction ..... 88
- 9. Compliance Plan ..... 88
- 10. Assessment of Compliance Activities ..... 89
- 11. Fraud Waste and Abuse Policies ..... 90
- 12. Review of Compliance Plan and Fraud, Waste and Abuse Policies ..... 91
- 13. Treatment of Overpayment Recoveries Due to Fraud, Waste and Abuse ..... 91
- 14. Audits of Network Providers ..... 92
- 15. Referral Policy ..... 92
- 16. Reporting Fraud, Waste and Abuse ..... 93

Exhibit B –Statement of Work - Part 10– Quality, Transformation, Performance Outcomes and Accountability  
96

- 1. Overview ..... 96
- 2. Transformation and Quality Strategy Requirements ..... 96
- 3. Revised Transformation and Quality Strategy ..... 97
- 4. Transformation and Quality Strategy Monitoring and Compliance Review ..... 97
- 5. Transformation and Quality Strategy Deliverables ..... 98
- 6. Goals for Transformation and Quality Strategy Amendments ..... 98
- 7. Quality and Performance Outcomes ..... 98
- 8. Performance Measurement and Reporting Requirements ..... 98
- 9. Quality Performance Improvement Projects ..... 99
- 10. Program Requirements ..... 100
- 11. External Quality Review ..... 100
- 12. Quality Pool ..... 101

Exhibit C – Consideration..... 104

- 1. Payment Types and Rates ..... 104
- 2. Payment in Full ..... 104
- 3. Changes in Payment Rates ..... 104
- 4. Timing of CCO Payments ..... 105
- 5. Settlement of Accounts ..... 106
- 6. CCO Risk Corridor ..... 108
- 7. Global Payment Rate Methodology ..... 111
- 8. Administrative Performance Penalty ..... 111
- 9. Quality Pool ..... 111
- 10. Minimum Medical Loss Ratio: ..... 111

Exhibit C – Consideration - Attachment 1 – CCO Payment Rates..... 113

Exhibit D – Standard Terms and Conditions ..... 114

- 1. Governing Law, Consent to Jurisdiction ..... 114
- 2. Compliance with Applicable Law ..... 114
- 3. Independent Contractor..... 115
- 4. Representations and Warranties..... 115
- 5. (Reserved) ..... 115
- 6. Funds Available and Authorized; Payments..... 115
- 7. Recovery of Overpayments..... 116
- 8. Indemnity ..... 116
- 9. Default; Remedies; and Termination ..... 117
- 10. Limitation of Liabilities ..... 124
- 11. Insurance ..... 124
- 12. Access to Records and Facilities..... 124
- 13. Information Privacy/Security/Access ..... 125
- 14. Force Majeure ..... 125
- 15. Foreign Contractor ..... 126
- 16. Assignment of Contract, Successors in Interest..... 126
- 17. Subcontracts ..... 126
- 18. No Third Party Beneficiaries ..... 126
- 19. Amendments ..... 126
- 20. Waiver..... 127
- 21. Severability ..... 127
- 22. Survival ..... 127
- 23. Notices ..... 129
- 24. Construction..... 130
- 25. Headings ..... 130
- 26. Merger Clause..... 130
- 27. Counterparts ..... 130
- 28. Equal Access..... 130
- 29. Media Disclosure ..... 130
- 30. Mandatory Reporting ..... 130

Exhibit E - Required Federal Terms and Conditions..... 131

- 1. Miscellaneous Federal Provisions..... 131
- 2. Equal Employment Opportunity..... 131
- 3. Clean Air, Clean Water, EPA Regulations ..... 131
- 4. Energy Efficiency ..... 132
- 5. Truth in Lobbying..... 132

- 6. HIPAA Compliance ..... 133
- 7. Resource Conservation and Recovery ..... 134
- 8. Audits ..... 134
- 9. Debarment and Suspension ..... 134
- 10. Pro-Children Act ..... 135
- 11. Additional Medicaid and CHIP ..... 135
- 12. Agency-based Voter Registration ..... 135
- 13. Clinical Laboratory Improvements ..... 135
- 14. Advance Directives ..... 136
- 15. Practitioner Incentive Plans (PIP) ..... 136
- 16. Risk HMO ..... 136
- 17. Conflict of Interest Safeguards ..... 136
- 18. Non-Discrimination ..... 138
- 19. OASIS ..... 138
- 20. Patient Rights Condition of Participation ..... 138
- 21. Federal Grant Requirements ..... 138
- 22. Mental Health Parity ..... 138
- Exhibit F – Insurance Requirements ..... 140
- Exhibit G – Reporting of Delivery System Network Providers, Cooperative Agreements, and Hospital Adequacy ..... 142
  - 1. Delivery System Network (DSN) Reports ..... 142
  - 2. DSN Provider Report ..... 142
  - 3. Provider Capacity ..... 144
  - 4. Cooperative Agreements with Publicly Funded Programs Report: ..... 145
  - 5. Cooperative Agreements with Community Social and Support Service and Long Term Care Report: ..... 145
  - 6. Hospital Network Adequacy ..... 146
- Exhibit H – Value Based Payment ..... 148
  - 1. VBP minimum threshold ..... 148
  - 2. Expanding ..... 148
  - 3. Patient-Centered Primary Care Home (PCPCH) VBP requirements ..... 149
  - 4. VBP Targets by Year ..... 149
  - 5. Contractor Data Reporting ..... 149
- Exhibit I – Grievance and Appeal System ..... 151
  - 1. Grievance and Appeal System ..... 151
  - 2. Grievances ..... 152
  - 3. Notice of Adverse Benefit Determination ..... 153
  - 4. Handling of Appeals ..... 156
  - 5. Contested Case Hearings ..... 159
  - 6. Continuation of Benefits: ..... 159
  - 7. Implementation of Reversed Appeal Resolution ..... 161
  - 8. Final Order on Contested Case Hearings ..... 161
  - 9. Record Keeping and Quality Improvement ..... 161
- Exhibit J - Health Information Technology ..... 164
  - 1. Health Information Technology Requirements ..... 164
  - 2. Health Information Technology (HIT) Roadmap ..... 165
- Exhibit L – Solvency Plan and Financial Reporting and Cost ..... 168
  - 1. Overview of Solvency Plan and Financial Reporting ..... 168
  - 2. Solvency Plan and Financial Reporting ..... 168
  - 3. Assumption of Risk/Private Market Reinsurance ..... 170

- 4. Restricted Reserve and Financial Solvency Requirement ..... 170
- Exhibit M-Behavioral Health..... 172
  - 1. Contractor Responsibilities ..... 172
  - 2. Covered Services ..... 173
  - 3. Care Coordination and Integration..... 180
  - 4. Children and Youth Behavioral Health Services ..... 188
  - 5. Reporting..... 193
  - 6. Providers ..... 195
- Exhibit N-Social Determinants of Health and Health Equity..... 196
  - 1. Community Advisory Council (CAC)..... 196
  - 2. Community Health Assessment (CHA) and Community Health Improvement Plan (CHP) ..... 197
  - 3. Social Determinants of Health and Health Equity ..... 199
  - 4. Health-Related Services ..... 201
  - 5. Health Plan..... 202
- Exhibit C-Attachment 1 ..... 207

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

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

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

xxxxx

xxxx

xxxx

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

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

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

**I. Effective Date and Duration**

- A.** This Contract is effective January 1, 2020 regardless of the date of signature. This Contract, including the CCO Payment Rates contained herein, is subject to approval by the US Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS). In the event CMS fails to approve the proposed 2020 CCO Payment Rates prior to the Effective Date, OHA shall pay Contractor at the proposed CCO Payment Rates, subject to adjustment upon OHA’s receipt of CMS approval or modification of the proposed CCO Payment Rates. Unless extended or terminated earlier in accordance with its terms, this Contract expires on December 31, 2020 (the “Expiration Date”). Assuming Contractor continues to satisfy Readiness Review standards and is otherwise in good standing, OHA will offer Contractor an annual Renewal Contract, subject to terms and conditions amending this Contract, for four additional annual terms so that the Contract will terminate December 31, 2024. Contract expiration or termination does not extinguish or prejudice OHA’s right to enforce this Contract with respect to any default by Contractor that has not been cured.

- B.** Contractor shall notify OHA not less than 120 days before the Expiration Date of its intent to not proceed with a Renewal Contract.

## **II. Contract in its Entirety**

- A.** This Contract consists of this document together with the following exhibits which are attached hereto and incorporated into this Contract by this reference, and the reporting forms described in Subsection B:

- Exhibit A:** Definitions
- Exhibit B:** Statement of Work
- Exhibit C:** Consideration \*
- Exhibit D:** Standard Terms and Conditions
- Exhibit E:** Required Federal Terms and Conditions
- Exhibit F:** Insurance Requirements
- Exhibit G:** Delivery System Network Provider and Hospital Adequacy Report Reporting Requirements
- Exhibit H:** Value-Based Payments
- Exhibit I:** Grievance System
- Exhibit J:** Health Information Technology
- Exhibit L:** Solvency Plan and Financial Reporting
- Exhibit M:** Behavioral Health
- Exhibit N:** Social Determinants of Health and Equity

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

- B.** Reporting forms and other reference documents are posted at <http://www.oregon.gov/OHA/healthplan/pages/CCO-Contract-Forms.aspx> the “Contract Reports Web Site”), and are by this reference incorporated into the Contract. OHA may change the Contract Reports Web Site after notice to Contractor. All completed reporting forms must be submitted by the Contractor’s Chief Executive Officer, Chief Financial Officer or an individual who has delegated authority to sign for the reports as designated by the Signature Authorization Form available on the Contract Reports Web Site.
- C.** There are no other Contract documents unless specifically referenced and incorporated in this Contract.

## **III. Vendor or Sub-Recipient Determination**

In accordance with the State Controller’s Oregon Accounting Manual, policy 30.40.00.102, OHA determines that:

Contractor is a sub-recipient; OR  Contractor is a vendor.

Catalog of Federal Domestic Assistance (CFDA) #(s) of federal funds to be paid through this Contract:  
CFDA 93.767 and CFDA 93.778

#### IV. Status of Contractor

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

B. Contractor designates:

xxx

xxx

xxx

Phone:

Fax:

Email:

as the point of contact pursuant to Exhibit D, Section 24 of this Contract. Contractor shall notify OHA in writing of any changes to the designated contact.

#### V. Enrollment Limits and Service Area

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

[enter limit] [enter county]

[enter limit] [enter county]

[enter limit] [enter county]

B. Contractor's maximum Enrollment limit is: (*Specific Plan Enrollment Limits*). The maximum Enrollment limit established in this section is expressly subject to such additional Enrollment as may be assigned to Contractor by OHA in Exhibit B, Part 3, Section 7, of this Contract; however, such additional Enrollment does not create a new maximum Enrollment limit.

#### VI. Interpretation and Administration of Contract

A. OHA has adopted policies, procedures, rules and interpretations to promote orderly and efficient administration of this Contract and to ensure Contractor's performance. In the provision of services under this Contract, the Contractor shall (1) comply with all applicable federal, and state laws and regulations, the terms of this Contract, reporting tools/ templates and all amendments thereto, that are in effect on the Effective Date or come into effect during the term of this Contract; and (2) require its Subcontractors to so comply.

B. In interpreting this Contract, the Parties shall construe its terms and conditions as much as possible to be complementary, giving preference to:

1. This Contract (without exhibits, attachments, or reference documents) over any exhibits, attachments, or reference documents.
2. The exhibit or attachment earlier in the Table of Contents over any exhibit or attachment later in the Table of Contents.
3. This Contract (with exhibits and attachments) over any reference documents.
4. Reference documents in alphabetical order.

C. In the event that the Parties need to look outside of this Contract for interpreting its terms, the Parties shall consider only the following sources, as in effect on the Effective Date, in the order of precedence listed:

1. The Oregon State Medicaid Plan and any Grant Award Letters, waivers or other directives or permissions approved by CMS for operation of the Oregon Health Plan (OHP).

2. The Federal Medicaid Act, Title XIX of the Social Security Act, the Children’s Health Insurance Program (CHIP), established by Title XXI of the Social Security Act, and the Patient Protection and Affordable Care Act (PPACA), and their implementing regulations published in the Code of Federal Regulations (CFR), except as waived by CMS for the OHP.
  3. The Oregon Revised Statutes (ORS) or other enacted Oregon Laws concerning the OHP.
  4. The Oregon Administrative Rules (OAR) promulgated by OHA prior to the Effective Date of this Contract or subsequent amendments to the Contract, to implement the OHP.
  5. The OARs promulgated after the Effective Date of this Contract or subsequent amendments to the Contract, if OHA includes with the rulemaking a statement that the rule either (a) is expected to have de minimis impact on CCO finances and operations; or (b) is required by changes in state law, changes in federal law or written guidance, or changes initiated by CMS in OHA’s OHP waivers or state plan.
  6. Other applicable Oregon statutes and OARs concerning the Medical Assistance Program and health services.
- D.** If Contractor believes that any provision of this Contract or OHA’s interpretation thereof is in conflict with federal or State statutes or regulations, Contractor shall notify OHA in writing immediately.

If any provision of this Contract is in conflict with applicable federal Medicaid or CHIP statutes or regulations that CMS has not waived for the OHP, Contractor shall enter into an amendment required by OHA to amend this Contract to conform to those laws or regulations.

**VII. Contractor Data and Certification**

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

If Contractor is self-insured for any of the Insurance Requirements specified in Exhibit F of this Contract, Contractor may so indicate by: (i) writing “Self-Insured” on the appropriate line(s); and (ii) submitting a certificate of insurance as required in Exhibit F, Section 9.

**Please print or type the following information**

NAME (exactly as filed with the IRS):

\_\_\_\_\_

Street Address: \_\_\_\_\_

City, state, zip code: \_\_\_\_\_

Telephone: ( ) \_\_\_\_\_ Facsimile Number: ( ) \_\_\_\_\_

E-mail address: \_\_\_\_\_

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

**(Check one box):**  YES  NO

Contractor Proof of Insurance:

All insurance listed must be in effect at the time of provision of services under this Contract.

Professional Liability Insurance Company \_\_\_\_\_

Policy # \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Commercial General Liability Insurance Company \_\_\_\_\_

Policy # \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Auto Insurance Company \_\_\_\_\_

Policy # \_\_\_\_\_ Expiration Date: \_\_\_\_\_

**Workers’ Compensation:** Does Contractor have any subject workers, as defined in ORS 656.027? **(Check one box):**  YES  NO *If YES, provide the following information:*

Workers’ Compensation Insurance Company: \_\_\_\_\_

Policy # \_\_\_\_\_ Expiration Date: \_\_\_\_\_

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

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

Professional Corporation

Nonprofit Corporation

Insurance Corporation

Limited Liability Company

Business Corporation

- B. Certification.** Without limiting the generality of the foregoing, by signature on this Contract, the Contractor hereby certifies that:
- 1.** The Contractor acknowledges that the Oregon False Claims Act, ORS 180.750 to 180.785, applies to any “claim” (as defined by ORS 180.750) that is made by (or caused by) the Contractor and that pertains to this Contract. The Contractor certifies that no claim described in the previous sentence is or will be a “False Claim” (as defined by ORS 180.750) or an act prohibited by ORS 180.755. Contractor further acknowledges that in addition to the remedies under this Contract, if it makes (or causes to be made) a False Claim or performs (or causes to be performed) an act prohibited under the Oregon False Claims Act, the Oregon Attorney General may enforce the liabilities and penalties provided by the Oregon False Claims Act against the Contractor.
  - 2.** Contractor certifies that Contractor has a written policy and practice that meets the requirements, described in ORS 279A.112, of preventing sexual harassment, sexual assault, and discrimination against employees who are members of a protected class. Contractor agrees, as a material term of the Contract, to maintain such a policy and practice in force during the entire Contract term.
  - 3.** Under penalty of perjury, the undersigned is authorized to act on behalf of Contractor and that Contractor is, to the best of the undersigned's knowledge, not in violation of any 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;
  - 4.** Contractor acknowledges that the Oregon Department of Administrative Services will report this Contract to the Oregon Department of Revenue (DOR). The DOR may take any and all actions permitted by law relative to the collection of taxes due to the State of Oregon or a political subdivision, including (i) garnishing the Contractor’s compensation under this Contract or (ii) exercising a right of setoff against Contractor’s compensation under this Contract for any amounts that may be due and unpaid to the State of Oregon or its political subdivisions for which the DOR collects debts;
  - 5.** The information shown in Part VII, Section A, “Contractor Data and Certification” above is Contractor's true, accurate and correct information;
  - 6.** To the best of the undersigned’s knowledge, 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;
  - 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>;
  - 8.** Contractor is not listed on the non-procurement portion of the General Service Administration’s “List of Parties Excluded from Federal procurement or Nonprocurement Programs” found at: <https://www.sam.gov/portal/public/SAM/> or such alternative system required for use by Medicaid programs;
  - 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.

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

C. By Contractor’s signature on this Contract, Contractor hereby certifies that the FEIN provided is true and accurate. If this information changes, Contractor is required to provide OHA with the new FEIN within 10 days.

**VIII. Signatures**

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

**CONTRACTOR**

By \_\_\_\_\_  
 Authorized \_\_\_\_\_ Date \_\_\_\_\_  
 Printed Name: \_\_\_\_\_  
 Title \_\_\_\_\_

**OHA – Health Systems Division**

By \_\_\_\_\_  
 Patrick Allen, Oregon Health Authority Director \_\_\_\_\_ Date \_\_\_\_\_  
 Printed Name \_\_\_\_\_

**Approved as to Legal Sufficiency:**

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

**Reviewed by OHA Contract Administration:**

By \_\_\_\_\_  
 Kathy Cereghino, Contract Administrator \_\_\_\_\_ Date \_\_\_\_\_

### **Exhibit A - Definitions**

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

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

For purposes of this Contract, in addition to terms defined elsewhere in this Contract, the terms below shall have the following meanings when capitalized. If a term below is used without capitalization in this Contract, then the context determines whether the term is intended to be used with the defined meaning.

**[See RFA Appendix A]**

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

### **1. Governing Board and Governance Structure**

Contractor shall establish, maintain, and operate with a Governance Structure that complies with the requirements of ORS 414.625 and OAR 410-141-3025.

Contractor shall provide annually to OHA the current organizational chart or listing presenting the identities of and interrelationships between the parent, the Contractor, Affiliated insurers and reporting entities, and other Affiliates. The organization chart must show all lines of ownership or Control up to Contractor’s ultimate controlling person, all subsidiaries of Contractor, and all Affiliates of Contractor that are relevant to this Application. When interrelationships are a 50/50% ownership, footnote any voting rights preferences that one of the entities may have. For each entity, identify the corporate structure, two-character state abbreviation of the state of domicile, Federal Employer’s Identification Number, and NAIC code for insurers. Schedule Y of the NAIC Annual Statement Blank—Health is acceptable to supply any of the information required by this question. If a subsidiary or other Affiliate performs business functions for Contractor, describe the functions in general terms.

Contractor shall provide annually to OHA a description of key committees including each committee’s composition, reporting relationships and responsibilities, oversight responsibility, monitoring activities and other activities performed.

### **2. Clinical Advisory Panel**

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

### **3. Innovator Agent and Learning Collaborative**

- a.** OHA will assign an Innovator Agent to the Contractor. The Innovator Agent’s roles are to act as a single point of contact between the Contractor and OHA on matters regarding innovation, to facilitate the exchange of information, to work with the Contractor and its Community Advisory Council, and to work with the Contractor to identify and develop strategies to support Quality Improvement and the adoption of innovations in care.
- b.** Contractor shall participate in face-to-face meetings of any CCO Learning Collaborative at least monthly, if available.

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

### **1. Covered Services**

Contractor shall provide and pay for Covered Services listed in this Exhibit B, in exchange for the CCO Payment described in Exhibit C.

- a.** Subject to the provisions of this Contract, Contractor shall provide to Members, at a minimum, those Covered Services that are Medically Appropriate and as described as funded Condition/Treatment Pairs on the Prioritized List of Health Services, including Ancillary Services, contained in OAR 410-141-0520 and as identified, defined and specified in the OHP Administrative Rules.
- b.** Contractor shall provide the Covered Services, including Diagnostic Services that are necessary and reasonable to diagnose the presenting condition, regardless of whether or not the final diagnosis is covered.
- c.** Contractor shall make available criteria for Medically Appropriate determinations with respect to Benefit Package for physical health, Behavioral Health (which includes mental health and Substance Use Disorders), and oral health to any Member, Potential Member or Participating Provider, upon request.
- d.** Contractor shall provide treatment, including Ancillary Services, which is included in or supports the Condition/Treatment Pairs that are above the funding line on the Prioritized List of Health Services, OAR 410-141-0520.
- e.** Except as otherwise provided in OAR 410-141-0480, Contractor is not responsible for excluded or limited services as described in OAR 410-141-0500.
- f.** Before denying treatment for a condition that is below the funding line on the Prioritized List of Health Services for any Member, especially a Member with a disability or Co-morbid Condition, Contractor shall determine whether the Member has a funded Condition/Treatment Pair that would entitle the Member to treatment under OAR 410-141-0480.
- g.** Contractor shall notify OHA's Transplant Coordinator of all transplant Prior Authorizations. Contractor must use the same limits and criteria for transplants as those established in the Transplant Services Rules, OAR Chapter 410 Division 124.
- h.** Contractor is prohibited from paying for organ transplants unless the State Plan, Section 1903(i), provides and the Contractor follows written standards that provide for similarly situated individuals to be treated alike and for any restriction on facilities or Practitioners to be consistent with the accessibility of high quality care to Members.
- i.** Contractor is responsible for Covered Services for Fully Dual Eligibles for Medicare and Medicaid. Contractor shall pay for Covered Services for Members who are Fully Dual Eligible in accordance with applicable contractual requirements that include CMS and OHA.

### **2. Provision of Covered Service**

- a.** Contractor may not arbitrarily deny or reduce the amount, duration, or scope of a Covered Service solely because of the diagnosis, type of illness, or condition, subject to the Prioritized List of Health Services.
- b.** Contractor shall ensure all Medically Appropriate Covered Services are furnished in an amount, duration and scope that is no less than the amount, duration and scope for the same services furnished to Clients under fee-for-service and as set forth in 42 CFR 438.210. Contractor also shall ensure that the Covered Services are sufficient in amount, duration and scope to reasonably

- be expected to achieve the purpose for which the services are furnished and include the following:
- (1) The prevention, diagnosis, and treatment of a disease, condition or disorder that results in health impairments or disability;
  - (2) The ability to achieve age-appropriate growth and development; and
  - (3) The ability to attain, maintain or regain functional capacity.
- c. Contractor shall establish written utilization management policies, procedures and criteria for Covered Services. These utilization management procedures must be consistent with appropriate utilization control requirements of 42 CFR Part 456, which includes minimum health record requirements in 42 CFR 456.111 and 42 CFR 456.211 for Hospitals and mental hospitals as listed below:
- (1) Identification of the Member;
  - (2) Physician name;
  - (3) Date of admission, dates of application for and authorization of Medicaid benefits if application is made after admission;
  - (4) The plan of care (as required under 45 CFR §456.180 for mental hospitals or 45 CFR §456.80 for hospitals);
  - (5) Initial and subsequent continued stay review dates (described under 42 CFR §456.233 and 456.234 for mental hospitals and 42 CFR §456.128 and 456.133 for hospitals);
  - (6) Reasons and plan for continued stay if applicable;
  - (7) Other supporting material the committee believes appropriate to include; and
  - (8) For non-mental hospitals only:
    - (a) Date of operating room reservation; and
    - (b) Justification of emergency admission if applicable.
- d. Contractor's utilization management policies may not be structured so as to provide incentives for its Provider Network, employees or other utilization reviewers to inappropriately deny, limit or discontinue Medically Appropriate services to any Member.
- e. Contractor shall ensure that medical necessity determination standards and any other quantitative or non-quantitative treatment limitations, applied to covered services, are no more restrictive than those applied to fee-for-service covered services, as described in 42 CFR 438.210(a)(5)(i).
- f. Contractor's policies and procedures relating to drug utilization review programs, including coverage criteria, are subject to approval by OHA and must be submitted for review and approval by OHA. Contractor's drug utilization review programs shall be developed in accordance with evidence-based practices based upon peer-reviewed, clinical literature and evidence-based practice guidelines from national and/or international professional organizations and in accordance with 42 CFR 438.3(s)(4)-(5). OHA will notify Contractor if it determines that Contractor's drug utilization review program is not compliant with applicable state or federal laws. If OHA determines that Contractor's drug utilization review policies are not compliant with applicable state or federal laws, Contractor shall revise its policies to be compliant.

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

- a.** Contractor shall establish and adhere to written policies and procedures for both the initial and continuing Service Authorization Requests. Contractor shall require its Participating Providers and Subcontractors to adhere to established policies for Service Authorization Requests. The procedures must require that any decision to deny a Service Authorization Request or to authorize a service in an amount, duration or scope that is less than requested, be made by a Health Care Professional who has appropriate clinical expertise in treating the Member's physical, mental or oral health condition or disease in accordance with 42 CFR §438.210.
- b.** Contractor may require Members and Subcontractors to obtain authorization for Covered Services from Contractor, except to the extent Prior Authorization is prohibited by OHP rules or elsewhere in this Contract.
- c.** Contractor may not require Members to obtain the approval of a Primary Care Physician in order to gain access to behavioral health Assessment and Evaluation services. Members may refer themselves to behavioral health services available from the Provider Network.
- d.** Contractor shall permit Members to refer themselves to a Traditional Health Worker for services within the scope of practice defined in Oregon Administrative Rule.
- e.** Contractor shall ensure the provision of sexual abuse exams without Prior Authorization.
- f.** Contractor shall have in effect mechanisms to ensure consistent application of review criteria for authorization decisions, taking into account applicable clinical practice guidelines, and consults with the requesting Provider when appropriate.
- g.** Contractors must permit out-of-network IHCPs to refer a CCO-enrolled Indian to a network provider for covered services as required by 42 CFR §438.14(b)(6).
- h.** For standard Service Authorization Requests, Contractor shall provide notice to the requesting provider as expeditiously as the Member's health or mental health condition requires, not to exceed 14 days following receipt of the request for service, with a possible extension of 14 additional days if the Member or Provider requests extension, or if the Contractor justifies a need for additional information and how the extension is in the Member's interest. If Contractor extends the time frame, Contractor shall provide the Member and Provider with a written notice of the reason for the decision to extend the timeframe and inform the Member of the right to file a Grievance if he or she disagrees with that decision. When a decision is not reached regarding a Service Authorization Request within the timeframes specified above, or if an CCO denies a service authorization request, or decides to authorize a service in an amount, duration, or scope that is less than requested, the Contractor shall issue a notice of adverse benefit determination to the Provider and Member, or Member Representative, consistent with Exhibit I, Grievance System.
- i.** If a Member or Provider suggests, or Contractor determines, that following the standard timeframes could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function, Contractor shall make an expedited service authorization decision, and provide Notice, as expeditiously as the member's health or mental health condition requires and no later than 72 hours after receipt of the request for service. Contractor may extend the 72 hour time period by up to 14 days if the Member requests an extension, or if Contractor justifies a need for additional information and how the extension is in the Member's interest.

- j.** For all covered outpatient drug authorization decisions, Contractor must provide a response as described in section 1927(d)(5)(A) of the Act and 42 USC 1396r–8(d)(5)(A) and OAR 410-141-3225.
- k.** Contractor may not restrict coverage for any Hospital length of stay following a normal vaginal birth to less than 48 hours, or less than 96 hours for a cesarean section. An exception to the minimum length of stay may be made by the Physician in consultation with the mother, which must be documented in the Clinical Record.
- l.** Contractor shall ensure that Dental Services which must be performed in an outpatient Hospital or ASC, due to the age, disability, or medical condition of the Member, are coordinated and preauthorized.
- m.** Except as provided in Subsection m. of this section, Contractor may not prohibit or otherwise limit or restrict Health Care Professionals who are its employees or Subcontractors acting within the lawful scope of practice, from advising or advocating on behalf of a Member, who is a patient of the Health Care Professional, for the following:
  - (1)** For the Member’s health status, medical care, or treatment options, including any alternative treatment that may be self-administered, that is Medically Appropriate even if such care or treatment is not covered under this Contract or is subject to Co-Payment;
  - (2)** Any information the Member needs in order to decide among relevant treatment options;
  - (3)** The risks, benefits, and consequences of treatment or non-treatment; and
  - (4)** The Member’s right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.
- n.** Notwithstanding the requirements of Subsection l. of this section, Contractor is not required to provide or reimburse for, or provide coverage of, a counseling or referral service if Contractor objects to the service on moral or religious grounds. If Contractor elects not to provide or reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds under this paragraph and such objection is not unlawful discrimination, Contractor shall adopt a written policy consistent with the provisions of 42 CFR 438.10 for such election and furnish information about the services Contractor does not cover.
  - (1)** If Contractor elects not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds under this paragraph, Contractor shall submit the policy as follows:
    - (a)** To the OHA Contract Administration Unit annually, no later than January 31<sup>st</sup>;
    - (b)** To OHA Contract Administration Unit upon any significant changes, prior to formal adoption of the policy. OHA will notify Contractor within 30 days of the compliance status of the policy; and
    - (c)** To the OHA Contract Administration Unit anytime upon OHA request. OHA will notify Contractor within 30 days of the compliance status of the policy.
  - (2)** Subject to OHA prior approval, Contractor shall furnish such information to:
    - (a)** Potential Members before and during Enrollment; and
    - (b)** Members 30 days prior to the effective date of the policy with respect to any particular service.

- o.** Contractor shall notify the requesting Provider, in writing or orally, when Contractor denies a request to authorize a Covered Service or when the Service Authorization Request is in an amount, duration, or scope that is less than requested.
- p.** Contractor shall notify the Member in writing of any decision to deny a Service Authorization Request, or to authorize a service in an amount, duration or scope that is less than requested pursuant to the requirements of Exhibit I.

#### **4. Covered Service Components**

Without limiting the generality of Contractor’s obligation to provide integrated care and coordination for Covered Services, the following responsibilities are required by law, and must be implemented in conjunction with its integrated care and coordination responsibilities stated above.

##### **a. Crisis, Urgent and Emergency Services**

- (1)** Contractor may not require Prior Authorization for Emergency Services nor limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.
- (2)** Contractor shall provide an after-hours call-in system adequate to Triage Urgent Care and Emergency Service calls, consistent with OAR 410-141-3140.
- (3)** Contractor shall cover and pay for Emergency Services, regardless of whether the provider that furnishes the services has a contract with Contractor, as provided for in OAR 410-141-3140.
- (4)** Contractor is encouraged to establish agreements with Hospitals in its Service Area for the payment of emergency screening exams.
- (5)** Contractor shall not deny payment for treatment obtained when a Member has an Emergency Medical Condition or Emergency Dental Condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of Emergency Medical Condition or Emergency Dental Condition.
- (6)** Contractor shall cover and pay for Post-Stabilization Services as provided for in OAR 410-141-3140 and 42 CFR 438.114. Contractor is financially responsible for Post-Stabilization Services obtained within or outside the Provider Network that are pre-approved by a Participating Provider or other Contractor representative as specified in 42 CFR 438.114(c)(1)(ii)(B). Contractor shall limit charges to Members for Post-Stabilization services to an amount no greater than what the Contractor would charge the Member for the services obtained within the Provider Network.
- (7)** Contractor’s financial responsibility for post-stabilization care services it has not pre-approved ends when the Member is discharged, consistent with the requirements of 42 CFR 438.114.
- (8)** Contractor shall cover Post Stabilization Services administered to maintain, improve, or resolve the Member’s stabilized condition without preauthorization, and regardless of whether the Member obtains the services within the Contractor’s network, when the Contractor could not be contacted for pre-approval or did not respond to a request for pre-approval within one hour.
- (9)** A Member who has an Emergency Medical Condition shall not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or to stabilize the Member. The attending emergency physician, or the Provider actually

treating the Member, is responsible for determining when the Member is sufficiently stabilized for transfer or discharge. Based on this determination, the Contractor will be liable for payment.

- (10) Contractor shall not refuse to cover Emergency Services based on the emergency room provider, hospital, or fiscal agent not notifying the Member's primary care provider of the Member's screening and treatment within 10 days of presentation for Emergency Services as specified in 42 CFR § 438.114
- (11) Contractor shall not deny payment for treatment obtained when a representative of the Contractor instructs the member to seek emergency services. 42 CFR § 438.114.
- (12) Contractor shall pay for emergency Ambulance transportation for Members including Ambulance services dispatched through 911, in accordance with the Emergency Services prudent layperson standard described in Exhibit A, definitions for "Emergency Services" and "Emergency Medical Condition."

**b. Non-Emergent Medical Transportation (NEMT)**

Contractor is responsible for ensuring members have access to safe, timely, appropriate Non-Emergent Medical Transportation services. Contractor shall develop and implement systems supported by written policies and procedures to describe the process for receiving member requests, approving NEMT services, and scheduling, assigning, and dispatching providers.

**(1) As part of the approval process, the Contractor shall:**

- (a) Verify the member's eligibility for NEMT services;
- (b) Determine the appropriate mode of transportation for the member;
- (c) Determine the appropriate level of service for the member;
- (d) Approve or deny the request; and
- (e) Enter the appropriate information into the Contractor's system.

**(2) Verifying Eligibility for NEMT Services**

The Contractor shall screen all requests for NEMT services to confirm each of the following items:

- (a) That the person for whom the transportation is being requested is an OHP enrollee and enrolled in the Contractor's CCO;
- (b) That the service for which NEMT service is requested is an OHP covered service or for flex services as determined by the CCO;
- (c) That the enrollee is eligible for services; and
- (d) That the transportation is a covered NEMT service.

**(3) Determining the Appropriate Mode of Transportation**

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

In order to determine the appropriate mode of transportation, the Contractor shall:

- (a) Determine whether the member is ambulatory and the member's current level of mobility and functional independence;

- (b) Determine whether the member will be accompanied by an attendant, and, if so, whether the member requires assistance and whether the attendant meets the requirements for an attendant;
- (c) Determine whether a member is under the age of eighteen (18) and will be accompanied by an adult; and
- (d) Assess any special conditions or needs of the member, including physical or behavioral health disabilities. Based on approval of previous NEMT services, the Contractor shall display members' permanent and temporary special needs, appropriate mode of transportation, and any other information necessary to ensure that appropriate transportation is approved and provided.

**(4) Timely access for NEMT services**

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

**(5) Requesting NEMT Services**

Members or their representatives shall be allowed to make requests for NEMT services on behalf of members. Representatives include the member's community health worker, foster parent, adoptive parent, or other provider delegated with this authority.

**(6) Scheduling, Assigning and Dispatching Trips**

- (a) The Contractor shall ensure that covered NEMT services are available twenty-four (24) hours a day, three hundred and sixty-five (365) days a year.
- (b) After approving a NEMT service to be provided by a NEMT provider (i.e., not fixed route), the Contractor shall schedule and assign the trip to an appropriate NEMT provider
- (c) The Contractor shall approve and schedule or deny a request for NEMT (including all legs of the trip) within twenty-four (24) hours of receiving the request. This timeframe shall be reduced as necessary to ensure the member arrives in time for his/her appointment. Failure to comply with this requirement may result in liquidated damages as described in the Contract and Oregon Administrative Rule.

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

**(7) Accommodating Scheduling Changes**

- (a) The Contractor shall accommodate unforeseen schedule changes and shall timely assign the trip to another NEMT provider if necessary. The Contractor shall ensure that neither NEMT providers nor drivers change the assigned pick-up time without permission from the Contractor.

**(8) Notifying Members**

If possible, the Contractor shall inform the member of the transportation arrangements during the phone call requesting the NEMT service. Otherwise, the Contractor shall obtain the member's preferred method (e.g., phone call, email, fax) and time of contact, and the Contractor shall notify the member of the transportation arrangements as soon as the arrangements are in place and prior to the date of the NEMT service.

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

**(9) Adverse Weather Plan**

The Contractor shall have policies and procedures for transporting members who need critical medical care, including but not limited to renal dialysis and chemotherapy, during adverse weather conditions. "Adverse weather conditions" includes, but is not limited to, extreme heat, extreme cold, flooding, tornado warnings and heavy snowfall. The policies and procedures shall include, at a minimum, staff training, methods of notification, and member education.

**(10) Contingency and Back-Up Plans**

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

**(11) Pick up and Delivery**

- (a) The Contractor shall ensure that drivers make their presence known to the member and wait until at least five (5) minutes after the scheduled pick-up time. If the member is not present five (5) minutes after the scheduled pick-up time, the driver must notify the dispatcher before departing from the pick-up location.
- (b) The Contractor shall ensure that drivers provide, at a minimum, the approved level of service (curb-to-curb, door-to-door, or hand-to-hand).
- (c) The Contractor shall ensure that members arrive at pre-arranged times for appointments and are picked up at pre-arranged times for the return leg of the trip.

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

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

**(12) Documentation of services**

- (a) Contractor shall maintain documentation of services provided that includes each trip, the Member ID, the destination, the reason the ride was requested (service reason), and any incidents of no-show on part of the driver or the member.
- (b) Contractor shall pay for coordination and provision of NEMT provided for Members if the Member is eligible for NEMT. Contractor's responsibility and Member eligibility for NEMT is specified in OAR 410-141-3435 through 410-141-3485.

**(13) NEMT Call Center**

- (a) Contractor shall maintain a NEMT Call Center to handle requests for NEMT services as well as questions, comments, and inquiries from members and their representatives, NEMT providers, and providers regarding NEMT services. The NEMT Call Center may use the same infrastructure as the Contractor's member services line, but the Contractor shall have a separate line or queue for NEMT calls, and NEMT Call Center staff shall be dedicated to NEMT calls.
- (b) The NEMT Call Center shall operate at a minimum, Monday through Friday from 9:00 a.m. to 5:00 p.m., but the brokerage may close the call center on New Year's Day, Memorial Day, July 4<sup>th</sup>, Labor Day, Thanksgiving, and Christmas. The Authority may approve, in writing, additional days of closure if the Contractor requests the closure at least thirty (30) days in advance.
- (c) For hours that the Contractor is using alternative arrangements to handle NEMT calls, the Contractor shall provide an afterhours message in, at a minimum, English and Spanish instructing the caller how to access the alternative arrangement (not requiring a second call) and also offering the caller the opportunity to leave a message utilizing a process in which all messages are returned within the next business day and efforts continue until the member is reached provided that the message left by the enrollee is discernible and includes a valid phone number in which the enrollee can be contacted. All efforts made to reach a member who has left a message shall be documented in order to demonstrate compliance with this requirement.

- (d) Contractor’s NEMT Call Center system shall have the capability to identify and record the phone number of the caller if the caller’s phone number is not blocked. Contractor shall have the capability of making outbound calls. Contractor shall maintain sufficient equipment and NEMT Call Center staff to handle anticipated call volume and ensure that calls are received and processed and the following performance standards for each line or queue:

  - i. Answer rate – At least eighty-five percent (85%) of all calls are answered by a live voice within thirty (30) seconds;
  - ii. Abandoned calls – No more than five percent (5%) of calls are abandoned; and
  - iii. Hold time – Average hold time, including transfers to other Contractor staff, is no more than three (3) minutes.
- (e) If a NEMT call cannot be answered by a live voice within thirty (30) seconds, the Contractor shall provide a message in, at a minimum, English and Spanish advising the caller that the call will not be answered promptly and offering the caller the opportunity to leave a message. If the message requests the Contractor to return the call, the Contractor shall promptly return the call within three (3) hours and continue the effort until the member is reached provided that the message left by the enrollee is discernible and includes a valid phone number in which the enrollee can be contacted. All efforts made to reach a member who has left a message shall be documented in order to demonstrate compliance with this requirement.
- (f) Contractor shall have qualified bi-lingual (English and, at minimum, Spanish) NEMT Call Center staff to communicate with callers who, at a minimum, speak Spanish, the Contractor shall provide oral interpretation services via a telephone interpretation service free of charge to callers with Limited English Proficiency. Contractor’s NEMT Call Center shall accommodate callers who are hearing and/or speech impaired.
- (g) Contractor shall operate an automatic call distribution system for its NEMT Call Center. Contractor shall route incoming calls to the NEMT Call Center to, at minimum, an English-speaking member queue, a Spanish-speaking member queue, a NEMT provider queue, and a provider healthcare queue. The welcome message for the NEMT Call Center shall be in English and shall include, at minimum, a Spanish language prompt.
- (h) Contractor shall develop NEMT Call Center scripts for calls requesting NEMT services that include a sequence of questions and criteria that the NEMT Call Center representatives shall use to determine the member’s eligibility for NEMT services, the appropriate mode of transportation, the purpose of the trip and all other pertinent information relating to the trip (see Section A.4 of this Attachment). The Contractor may develop additional scripts for other types of NEMT calls from members, healthcare providers, and NEMT providers. Any script for use with an enrollee shall be written at the sixth (6th) grade reading level and must be prior approved in writing by OHA. Contractor shall advise callers that calls to the NEMT Call Center are monitored and recorded for quality assurance purposes.

- (i) Contractor shall record a statistically valid sample of incoming and outgoing calls to/from the NEMT Call Center for quality control, program integrity and training purposes. Contractor shall monitor and audit at least one percent (1%) of calls of each NEMT Call Center staff member on a monthly basis. The Contractor shall develop a tool for auditing calls, which shall include components to be audited and the scoring methodology. The Contractor shall use this monitoring to identify problems or issues, for quality control, and for training purposes. The Contractor shall document and retain results of this monitoring and subsequent training.
- (j) Contractor's NEMT Call Center system shall be able to produce the reports required under the contract and ad hoc reports that OHA may request. Contractor shall analyze data collected from its NEMT Call Center system as necessary to perform quality improvement, fulfill the reporting and monitoring requirements of the Contract, and ensure adequate resources and staffing.

**(14) NEMT Quality Assurance Program**

As part of the Contractor's Compliance Plan required by the Contract, the Contractor shall develop policies and procedures outlining the activities for ongoing monitoring, evaluation and improvement of the quality and appropriateness of NEMT services. The NEMT Quality Assurance Plan shall include at least the following:

- (a) Contractor's procedures for monitoring and improving member satisfaction with NEMT services;
- (b) Contractor's procedures for ensuring that all NEMT services paid for are properly approved and actually rendered, including but not limited to validation checks and an annual analysis matching physical health and behavioral health claims/encounters and NEMT claims/encounters;
- (c) Contractor's procedures for monitoring and improving the quality of transportation provided pursuant to the Contract, including transportation provided by fixed route; and
- (d) Contractor's monitoring plan for NEMT providers.

**(15) NEMT Reports**

Contractor shall submit a quarterly report that provides a summary and detail statistics on the NEMT Call Center telephone lines/queues and includes calls received, calls answered, total calls received during regular business hours and total calls received after business hours.

**(16) Accidents and Incidents**

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

**(17) NEMT Complaints**

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

**c. Preventive Care**

- (1)** Contractor shall provide preventive services, defined as those services promoting physical, oral and mental health or reducing the risk of disease or illness included under OAR 410-120-1210, 410-123-1220, 410-123-1260, 410-141-0480, and 410-141-0520. Such services include, but are not limited to, periodic medical examinations based on age, gender and other risk factors; screening tests; immunizations; and counseling regarding behavioral risk factors.
- (2)** Preventive services screening and counseling content is based on age and risk factors determined by a comprehensive patient history. Contractor must provide all necessary diagnosis and treatment services identified as a result of such screening to the extent such services are Covered Services. To the extent such services are Non-Covered Services, but are Medical Case Management Services, Contractor must refer the Member to an appropriate Participating or Non-Participating Provider and manage and coordinate the services.
- (3)** For Preventive Services provided through any Subcontractors (including, but not limited to, FQHCs, Rural Health Clinics, and County Health Departments), Contractor shall require that all services provided to Members are reported to Contractor and are subject to Contractor's Medical Case Management and Record Keeping responsibilities.
- (4)** Contractors shall comply with the mission, objectives, and guidelines of the Quality and Performance Improvement Workgroup, as posted on OHA's web site. This includes, but is not limited to, specific prevention projects, both at the Contractor and State levels, collection and measurement of data, and regular intervals of data submissions.

**d. Family Planning Services**

Members may receive Covered Services for Family Planning from any OHA Provider as specified in the Social Security Act, Section 1905 [42 U.S.C. 1396d], 42 CFR 431.51 and defined in OAR 410-130-0585. To the extent the Member chooses to receive such services without Contractor's authorization from a Provider other than Contractor or its Subcontractors, Contractor is not responsible for payment, Case Management, or Record Keeping.

**e. Sterilizations and Hysterectomies**

- (1)** Sterilizations and Hysterectomies are a Covered Service only when they meet the federally mandated criteria in 42 CFR 441.250 to 441.259 and the requirements of OHA established in OAR 410-130-0580. Member Representatives may not give consent for sterilizations.
- (2)** Contractor shall submit a signed informed consent form to OHA Contract Administration Unit for each Member that received either a hysterectomy or sterilization service as described in Subsection (1) above. Contractor may submit copies of informed consent

forms upon receipt or when notified by OHA that a qualifying encounter claim has been identified.

- (3) OHA will notify Contractor no later than 30 days past the end of each calendar quarter of Contractor's Members who received a hysterectomy or sterilization service. Contractor in turn shall supply the informed consent within 30 days of notification to the Contractor's designated Encounter Data Liaison.
- (4) OHA in collaboration with Contractor reconciles all hysterectomy or sterilization services with informed consents with the associated encounter claims by either:
  - (a) Confirming the validity of the consent and notifying Contractor that no further action is needed;
  - (b) Requesting a corrected informed consent form; or
  - (c) Informing Contractor the informed consent is missing or invalid and Provider must recoup the payment and must change the associated encounter claim to reflect no payment made for service(s).
- (5) Contractor will be subject to Overpayment recovery as described in Exhibit D, Section 7 of this Contract for failure to comply with the requirements of this section.

**f. Post Hospital Extended Care (PHEC) Coordination**

- (1) PHEC is a 20-day benefit included within the Global Budget payment. Contractor shall make the benefit available for non-Medicare Members who meet Medicare criteria for a post-hospital skilled Nursing Facility placement.
- (2) Contractor shall notify the Member's local DHS APD office as soon as the Member is admitted to PHEC. The Contractor and APD will begin appropriate discharge planning.
- (3) Contractor shall notify the Member and the facility of the proposed discharge date from PHEC no later than two full days prior to discharge.
- (4) Contractor shall provide the PHEC benefit according to the criteria established by Medicare, as cited in the Medicare Coverage of Skilled Nursing Facility Care available by calling 1-800-MEDICARE or at [www.medicare.gov/publications](http://www.medicare.gov/publications).
- (5) Contractor is not responsible for the PHEC benefit unless the Member was enrolled with Contractor at the time of the hospitalization preceding the skilled Nursing Facility placement.

**g. Medication Management**

- (1) Except as otherwise provided in this Contract, prescription drugs are a Covered Service for funded Condition/Treatment Pairs, and Contractor shall pay for Prescription Drugs. Contractor shall provide covered prescription drugs in accordance with OAR 410-141-3070. Prescription drugs and drug classes covered by Medicare Part D for Fully Dual Eligible Members are not a Covered Service. OHA will continue to cover selected drugs that are excluded from Medicare Part D coverage, pursuant to OAR 410-120-1210. Prescription drugs covered by the Contractor shall be made available on Contractor's website in a machine readable format.
- (2) Contractor shall operate a Drug Use Review (DUR) program that meets the definition and standards in 42 CFR §438.3. Contractor shall participate and coordinate response to CMS annual DUR survey, for reporting period October 1, 2018-September 30, 2019.

Contractor shall submit completed survey to, OHA CCO Contract Administrator by June 1, 2020 and shall participate, coordinate and respond to any future CMS DUR survey inquiries.

- (3)** Contractor shall develop policies and procedures to ensure children, especially those in custody of DHS, who need or who are being considered for psychotropic medications, receive medications that are for medically accepted indications. Contractor shall prioritize service coordination and the provision of other mental health services and supports for these children.
- (4)** Requirements for Agreements with Pharmacy Benefit Managers

  - (a)** Contractor shall ensure that contracts with Pharmacy Benefit Managers meet requirements related to transparency, rebate pass back, cost pass-through at 100%, reporting of administrative fees and of pharmacy paid-amounts at a claim level.
  - (b)** Contractor shall obtain third party market check and audit on an annual basis to ensure PBM is compliant with requirements and is market competitive. This third party market check and audit shall:

    - i.** Be completed and delivered to Contractor by July 1 each year (beginning in 2021) and subsequently shared with the Oregon Health Authority within 7 days of delivery;
    - ii.** Clearly identify the comparator data used as a benchmark for this market check and the current performance of the PBM
  - (c)** Contractor shall include language within its Pharmacy Benefit Management contract that the PBM agreement is subject to renegotiation based on the market check report findings, and includes the following contractual provisions:

    - i.** If the market check report finds that current market conditions can yield “in the aggregate” gross plan pharmacy cost savings (defined as eligible charges plus base administrative fees) from three quarters of a percent (0.75%) to ninety-nine one hundredths of a percent (0.99%), the parties may elect to initiate discussions to review the existing pricing terms and other applicable provisions under the PBM Agreement to establish whether an adjustment should be considered.
    - ii.** If the market check report finds that current market conditions can yield “in the aggregate” gross plan pharmacy cost savings of a one percent (1.0%) or more, the parties shall negotiate in good faith and execute a revision to the existing pricing terms and other applicable provisions under the PBM Agreement within 30 days, to be effective on the later of 30 days post signature or by no later than October 1st of the evaluation year.
  - (d)** No-spread PBM contracting requirement does not preclude a pay for performance model contract. If utilizing a pay for performance contract with its PBM, Contractor shall ensure that the terms of that contract must be transparent and understood by OHA. If seeking to use a pay-for-performance PBM contract, Contractor shall submit the model contract to OHA for approval before implementation.

- (e) Contractor shall align its prescription drug formulary with the fee-for-service Preferred Drug List (PDL) for any and all medications in drug classes required by OHA.
- (f) Contractors’s Requirements for PDL alignment include:
  - i. Identical preferred and non-preferred status; and
  - ii. Identical criteria for prior authorization for all medications on the PDL
- (g) Information on Contractor’s prescription drug formulary, including coverage and PA approval criteria, shall be publicly posted and readily accessible by patients, prescribers, dispensing pharmacies, and OHA staff. Contractor’s prescription drug formulary shall be updated in a timely manner prior to implementing changes made to either coverage or PA criteria.

**h. Intensive Care Coordination**

- (1) Contractor is responsible for Intensive Care Coordination services. This section sets forth the elements and requirements for Intensive Care Coordination.
- (2) Contractor shall make trauma informed, culturally responsive and linguistically appropriate Intensive Care Coordination Services available to Members identified as aged, blind, or disabled, Members with Special Health Care Needs, Members who are part of a Prioritized Population, Members who have complex medical needs, high health care needs, multiple chronic conditions or Behavioral Health issues, and for Members with severe and persistent mental illness receiving home and community-based services under the State’s 1915(i) State Plan Amendment. Intensive Care Coordination services may be requested by the Member, the Member Representative, Physician, other medical personnel serving the Member, or the Member's agency case manager.
- (3) Contractor shall respond to requests for Intensive Care Coordination services with an initial response by the next Business Day following the request.
- (4) Contractor shall periodically inform all Participating Providers of the availability of Intensive Care Coordination services, provide training for PCPCHs and other PCP’s staff on Intensive Care Coordination services and other support services available for Members.
- (5) Contractor shall assure that the case manager’s name and telephone number are available to agency staff and Members or Member Representatives when Intensive Care Coordination services are provided to the Member.
- (6) Contractor shall make Intensive Care Coordination services available to coordinate the provision of all Covered Services to Members who exhibit inappropriate, disruptive, or threatening behaviors in a Practitioner's office or clinic or other health care setting.
- (7) Additional Intensive Care Coordination responsibilities are outlined in Exhibit M of this Contract.

**i. Tobacco Cessation**

Contractor shall provide for: culturally responsive and linguistically appropriate tobacco dependence Assessments, systematically and on-going; and cessation intervention, treatment, and counseling services consistent with recommendations listed in the Tobacco Cessation standards located at:

<http://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/TOBACCOPREVENTION/Docum>

[ents/tob\\_cessation\\_coverage\\_standards.pdf](#). Contractor shall make these services available to all Members assessed to use tobacco products including smokeless, dissolvable, electronic vapor, pipes and cigars. Contractor shall establish a systematic mechanism to document and report dependency and cessation services. Contractor may refer to accepted published evidence-based Community Standards, the national standard or as outlined in OAR 410-130-0190.

**j. Breast and Cervical Cancer Program Members**

Contractor shall identify a primary treating professional for each Member receiving Covered Services on the basis of Breast and Cervical Cancer eligibility. For purposes of this section, “primary treating professional” means a health care professional responsible for the treatment of the breast or cervical cancer. OHA may monitor encounter data to identify these Members who have ceased receiving treatment services. Contractor shall respond to OHA requests for the treating health professional to confirm whether the Member’s course of treatment is complete. Services received as part of the Breast and Cervical Cancer Program are exempt from a copay as stated in OAR 410-120-1230.

**k. 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 OAR Chapter 410 Division 141 applicable to DCOs and with the terms of this Contract.
- (2) Contractor shall establish written policies and procedures for Emergency Dental Services and Urgent Care Services for Emergency Dental Conditions that are consistent with OAR 410-141-3220(8). The policies and procedures must describe when treatment of an Emergency Dental Condition or Urgent Care Service should be provided in an ambulatory dental office setting, and when Emergency Dental Services should be provided in a hospital setting.
  - (a) For routine oral health care the Member shall be seen within eight weeks unless there is a documented special clinical reason which would make access longer than eight weeks appropriate. Routine oral health treatment or treatment of incipient decay does not constitute emergency care.
  - (b) For an Emergency Dental Service, the Member must be seen or treated within 24 hours; and for an Urgent Dental Service, the Member must be seen or treated within 72 hours or as indicated in initial screening. The treatment of an Emergency Dental Condition is limited to Covered Services. OHA recognizes that some Non-Covered Services may meet the criteria of treatment for the Emergency Dental Condition, however this Contract does not extend to those Non-Covered Services.

**5. Non-Covered Health Services with Care Coordination**

- a. Contractor shall coordinate services for each Member who requires health services not covered under the CCO Payment.
- b. Contractor shall assist its Members in gaining access to certain behavioral health services that are not Covered Services and that are provided under separate contract with OHA, including but are not limited to the following:
  - (1) Standard therapeutic class 7 & 11 Prescription drugs, Depakote, Lamictal and their generic equivalents dispensed through a licensed pharmacy. These medications are paid through OHA’s Fee for Service system;

- (2) Therapeutic Foster Care reimbursed under HCPCS Code S5146 for Members under 21 years of age;
- (3) Therapeutic group home reimbursed for Members under 21 years of age;
- (4) Behavioral rehabilitative services that are financed through Medicaid and regulated by DHS Child Welfare and OYA;
- (5) Investigation of Members for Civil Commitment;
- (6) Long Term Psychiatric Care (LTPC) for Members 18 years of age and older;
- (7) Preadmission Screening and Resident Review (PASRR) for Members seeking admission to a LTPC;
- (8) Long Term Psychiatric Care (LTPC) for Members age 17 and under, including:
  - (a) Secure Children's Inpatient program (SCIP),
  - (b) Secure Adolescent Inpatient Program (SAIP), or
  - (c) Stabilization and transition services (STS);
- (9) Personal care in adult foster homes for Members 18 years of age and older;
- (10) Residential mental health services for Members 18 years of age and older provided in licensed community treatment programs;
- (11) Abuse investigations and protective services as described in OAR 407-045-0000 through 407-045-0370 and ORS 430.735 through 430.765; and
- (12) Personal Care Services as described in OAR 411-034-0000 through 411-034-0090 and OAR 309-040-0300 through 309-040-0330.

**6. Non-Covered Health Services without Care Coordination**

Non-Covered Services for which Contractor does not need to provide care coordination include but are not limited to:

- a. Physician assisted suicide under the Oregon Death with Dignity Act, ORS 127.800-127.897;
- b. Hospice services for Members who reside in a skilled Nursing Facility;
- c. Long term care services excluded from Contractor reimbursement pursuant to ORS 414.631;
- d. School-based services that are Covered Services provided in accordance with Individuals with Disabilities Education Act (IDEA) requirements that are reimbursed with the educational services program;
- e. Administrative examinations requested or authorized in accordance with OAR 410-130-0230; and
- f. Services provided to CAWEM recipients or CAWEM Plus-CHIP Prenatal Coverage for CAWEM.

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

### **1. Member and Member Representative Engagement and Activation**

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

Contractor shall demonstrate how it:

- a. Uses Community input and the Community Health Assessment (CHA) process to help determine the most culturally responsive and linguistically appropriate and effective methods for patient activation, with the goal of ensuring that Members are partners in maintaining and improving their health;
- b. Engages Members to participate in the development of holistic approaches to patient engagement and responsibility that account for social determinants of health and health disparities;
- c. Educates Members on how to navigate the coordinated and integrated health system developed by Contractor by means that may include Traditional Health Workers as part of the Member’s primary care team;
- d. Encourages Members to make healthy lifestyle choices and to use wellness and prevention resources, including mental health and addictions treatment, culturally-specific resources provided by community based organizations and service providers;
- e. Provides plain language narrative and alternative (video or audio) formats for individuals with limited literacy to inform Members of rights and responsibilities; and
- f. Meaningfully engages the CAC to monitor patient engagement and activation.

### **2. Member Rights under Medicaid**

Contractor shall have written policies regarding the Member rights and responsibilities under Medicaid law specified below and Contractor shall:

- a. Ensure Members are aware that a second opinion is available from a qualified Health Care Professional within the Provider Network, or that the Contractor will arrange for Members to obtain a qualified Health Care Professional from outside the Provider Network, at no cost to the Members.
- b. Ensure Members are aware of their civil rights under Title VI of the Civil Rights Act and ORS Chapter 659A, that Member has a right to report a complaint of discrimination by contacting the Contractor, OHA, the Bureau of Labor and Industries (BOLI) or the Office of Civil Rights (OCR).
- c. Provide notice to Members of Contractor’s nondiscrimination policy and process to report a complaint of discrimination on the basis of race, color, national origin, religion, sex, sexual orientation, marital status, age, or disability in accordance with all applicable laws including Title VI of the Civil Rights Act and ORS Chapter 659A.
- d. Provide equal access for both males and females under 18 years of age to appropriate facilities, services and treatment under this Contract, consistent with OHA obligations under ORS 417.270.

- e. Make Certified or Qualified Health Care Interpreter services available free of charge to each Potential Member and Member. This applies to all non-English languages, not just those that OHA identifies as prevalent. Contractor shall notify its Members and Potential Members that oral interpretation is available free of charge for any language and that written information is available in prevalent non-English languages in Service Area(s) as specified in 42 CFR 438.10(d)(4). Contractor shall notify its Members how to access oral interpretation and written translation services
- f. Have in place a mechanism to help Members and Potential Members understand the requirements and benefits of Contractor's plan and develop and provide written information materials and educational programs consistent with the requirements of OAR 410-141-3280 and 410-141-3300.
- g. Allow each Member to choose his or her health professional from available Participating Providers and facilities to the extent possible and appropriate. For a Member in a Service Area serviced by only one PHP, any limitation the Contractor imposes on his or her freedom to change between PCPs or to obtain services from Non-Participating Providers if the service or type of provider is not available with the Contractor's Provider Network may be no more restrictive than the limitation on Disenrollment under Exhibit B, Part 3, Section 6.b.
- h. Require, and cause its Participating Providers to require, that Members receive information on available treatment options and alternatives presented in a manner appropriate to the Member's condition, preferred language and ability to understand.
- i. Allow each Member the right to be actively involved in the development of Treatment Plans if Covered Services are to be provided and to have Family involved in such treatment planning.
- j. Allow each Member the right to request and receive a copy of his or her own Health Record, (unless access is restricted in accordance with ORS 179.505 or other applicable law) and to request that the records be amended or corrected as specified in 45 CFR Part 164.
- k. Furnish to each of its Members the information specified in 42 CFR 438.10(f)(2)-(3), and 42 CFR 438.10(g), if applicable, as specified in the CFR within 30 days after the Contractor receives notice of the Member's Enrollment from OHA or for Members who are Fully Dual Eligible, within the time period required by Medicare. Contractor shall notify all Members of their right to request and obtain the information described in this section at least once a year.
- l. Ensure that each Member has access to Covered Services which at least equals access available to other persons served by Contractor.
- m. Ensure Members are free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliations specified in federal regulations on the use of restraints and seclusion.
- n. Require, and cause its Participating Providers to require, that Members are treated with respect, with due consideration for his or her dignity and privacy, and the same as non-Members or other patients who receive services equivalent to Covered Services.
- o. Ensure that each Member is guaranteed the right to participate in decisions regarding his or her health care, including the right to refuse treatment, and has the opportunity to execute a statement of wishes for treatment, including the right to accept or refuse medical, surgical, or behavioral health treatment and the right to execute directives and powers of attorney for health care established under ORS 127.505 to 127.660 and the OBRA 1990 -- Patient Self-Determination Act.

- p.** Ensure, and cause its Participating Providers to ensure, that each Member is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the Contractor, its staff, Subcontractors, Participating Providers or OHA, treat the Member. Contractor shall not discriminate in any way against Members when those Members exercise their rights under the OHP.
- q.** Ensure that any cost sharing authorized under this Contract for Members is in accordance with 42 CFR 447.50 through 42 CFR 447.90 and with the General Rules.
- r.** Notify Members of their responsibility for paying a Co-Payment for some services, as specified in OAR 410-120-1230.
- s.** If available, utilize electronic methods of communications with Members, at their request, to provide Member information.
- t.** Contractor may use electronic communications for purposes described in Subsection s above only if:
  - (1)** The recipient has requested or approved electronic transmittal;
  - (2)** The identical information is available in written form upon request;
  - (3)** The information does not constitute a direct Member notice related to an adverse Action or any portion of the Grievance, Appeals, Contested Case Hearings 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.

### **3. Provider's Opinion**

Members are entitled to the full range of their health care Provider's opinions and counsel about the availability of Medically Appropriate services under the OHP.

### **4. Informational Materials and Education of Members and Potential Members**

- a.** Contractor shall assist Members and Potential Members in understanding the requirements and benefits of Contractor's integrated and coordinated care plan. Contractor shall develop and provide written information materials and educational programs consistent with the requirements of OAR 410-141-3280, 410-141-3300, 42 CFR 438.10 and 42 CFR 438.10(e)(2)(i), providing general information to potential Members about:
  - (1)** Basic features of managed care;
  - (2)** Which populations are excluded from enrollment, subject to mandatory enrollment, or free to enroll voluntarily in the program;
  - (3)** Contractor's responsibilities for coordination of Member care;
  - (4)** The services area covered by the Contractor;
  - (5)** Covered benefits;
  - (6)** The provider directory; and
  - (7)** The requirement for the Contractor to provide adequate access to covered services;

Written notice must be translated for Members who speak prevalent non-English languages as provided by OHA in accordance with 42 CFR 438.10 (d)(1), and as defined in 42 CFR 438.10

- (c), and notices must include language clarifying that auxiliary aids and oral interpretation is available for all languages and how to access these services.
- b.** Contractor shall develop and provide written informational materials and educational programs as described in OAR 410-141-3280 and OAR 410-141-3300. Contractor shall submit all member notices and informational material to OHA Materials Coordinator for review and approval no less than 30 days prior to use. Contractor shall furnish to each of its Members a Member handbook that contains all of the information specified in Member Communication Requirements, located on CCO Forms webpage, consistent with the requirements of 42 CFR 438.10(h), if applicable, within a reasonable time after the Contractor received notice of the recipient's Enrollment from OHA or for clients who are Fully Dual Eligible, within the time period required by Medicare. Contractor shall notify all Members of their right to request and obtain the information described in this section at least annually. These materials and programs shall be in a manner and format that may be easily understood and tailored to the backgrounds and special needs of Members and Potential Members. Contractor shall develop, and make available to its Members, a health and wellness education program that addresses Prevention and Early Intervention of illness and disease. Contractor shall distribute an approved handbook to new Members, within 14 days of the Member's effective date of coverage with Contractor, which includes the information provided in Member Communication Requirements, located on CCO Forms webpage.
  - c.** Health education shall include: 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).
  - d.** Contractor shall provide additional information that is available upon request by the Member, including information on Contractor's structure and operations, and Physician Incentive Plans.
  - e.** Contractor shall ensure that all Contractor's staff who have contact with Potential Members are fully informed of Contractor policies, including Enrollment, Disenrollment, and Fraud, Waste and Abuse, Grievance and Appeal policies, advance directive policies and the provision of Certified or Qualified Health Care Interpreter services including the Participating Provider's offices that have bilingual capacity.
  - f.** Contractor shall provide written notice to affected Members of any Material Change in the information described in Subsection e of this section, pertaining to program, policies and procedures that are reasonably likely to impact the affected Member's ability to access care or services from Contractor's Participating Providers. Such notice shall be provided at least 30 days prior to the intended effective date of those changes, or as soon as possible if the Participating Provider(s) has not given the Contractor sufficient notification to meet the 30 day notice requirement. The OHA Materials Coordinator will review and approve such materials within two Business Days.
  - g.** Contractor shall make its written material available in alternative formats including auxiliary aids, and in an appropriate manner that takes into account the special needs of those who, for example, are visually limited or have limited reading proficiency. All Members and Potential Members must be informed that Contractor's written information is available in alternative formats, free of charge, and how to access those formats.
  - h.** Contractor shall ensure the Member handbook reflects information on how Members can report suspected Fraud, Waste and Abuse.

## 5. Grievance System

- a.** Contractor shall have a Grievance System, supported with written procedures, for Members that includes a Grievance process, Appeal process and access to Contested Case Hearings. Contractor's Grievance System shall meet the requirements of Exhibit I, OAR 410-141-3225 through 410-141-3255, and 42 CFR 438.400 through 438.424. The Grievance System must include Grievances and Appeals related to requests for accommodation in communication or provision of services for Members with a disability or limited English proficiency. OHA will review the Contractor's procedures for compliance and notify Contractor when approved. Upon any change to the approved procedures, Contractor shall submit the changes to OHA Contract Administration Unit for approval. Contractor shall review its Grievance System policies annually and submit as follows:
- (1) To the OHA Contract Administration Unit annually no later than January 31<sup>st</sup>.
  - (2) To the OHA Contract Administration Unit upon any significant changes, prior to formal adoption of the policy. OHA will notify Contractor within 30 days of the compliance status of the policy.
  - (3) To the OHA Contract Administration Unit anytime upon OHA request. OHA will notify Contractor within 30 days of the compliance status of the policy.
- b.** Contractor shall provide to all Providers and Subcontractors, at the time they enter into a subcontract, the following Grievance, Notice of Adverse Benefit Determination, Appeal and Contested Case Hearing procedures and timeframes:
- (1) The Member's right to a Contested Case Hearing, how to obtain a hearing and representation rules at a hearing;
  - (2) The Member's right to file Grievances and Appeals and their requirements and timeframes for filing;
  - (3) The availability of assistance in filing;
  - (4) The toll-free numbers to file oral Grievances and Appeals;
  - (5) The Member's right to request continuation of benefits during an Appeal or Contested Case Hearing filing and, if the Contractor's Action is upheld in a Contested Case Hearing, the Member may be liable for the cost of any continued benefits; and
  - (6) Any State-determined Provider appeal rights to challenge the failure of the organization to cover a service.
  - (7) Contractor shall monitor the compliance of its subcontractor and provider network to all Grievance and Appeal requirements outlined in federal and State law and the provisions of this contract.

## 6. Enrollment and Disenrollment

### a. Enrollment

1. An individual becomes a Member for purposes of this Contract in accordance with OAR 410-141-3060 as of the date of Enrollment with Contractor. As of that date, Contractor shall provide all Covered Services to such Member as required by the terms of this Contract.

- (a) For persons who are enrolled on the same day as they are admitted to the Hospital or, for children and adolescents admitted to psychiatric residential treatment services (PRTS), Contractor is responsible for said services.
  - (b) If the person is enrolled after the first day of Hospital stay or PRTS, the person will be disenrolled, and the date of Enrollment shall be the next available Enrollment date following discharge from Hospital services or PRTS.
  - (c) For persons who are enrolled on the same day as they are admitted to the residential treatment services, Contractor is responsible for said services.
  - (d) If the person is enrolled after the first day of admission to the residential treatment services, the person will be disenrolled, and the date of Enrollment shall be the next available Enrollment date following discharge from the residential treatment services.
2. The provisions of this section apply to all Enrollment arrangements as specified in OAR 410-141-3060. OHA will enroll a Member with the CCO selected by the Member. If an eligible Member does not select a CCO, OHA may assign the Member to a CCO selected by OHA in accordance with 42 USC 1396u-2(a)(4)(D). Contractor shall have an open Enrollment period at all times, during which Contractor shall accept, without restriction, all eligible Members in the order in which they apply and are enrolled with Contractor by OHA, unless Contractor's Enrollment is closed under Paragraph (5).
3. Contractor shall not discriminate against individuals eligible to enroll on the basis of health status, the need for health services, race, color, national origin, religion, sex, sexual orientation, marital status, age, gender identity, or disability and shall not use any policy or practice that has the effect of discriminating on the basis of race, color, national origin, religion, sex, sexual orientation, marital status, age, gender identity or disability.
4. Contractor shall not seek the disenrollment of a member on the basis of health status, the need for health services, race, color, national origin, religion, sex, sexual orientation, marital status, age, gender identity or disability.
5. Enrollment with Contractor may be closed by OHA, or by Contractor notifying the designated OHA CCO Coordinator, because Contractor's maximum Enrollment has been reached or for any other reason mutually agreed to by OHA and Contractor, or as otherwise authorized under this Contract or OAR 410-141-3060.
6. 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.
7. If OHA enrolls a Member with Contractor in error, OHA will apply the Disenrollment rules in OAR 410-141-3080 and may retroactively disenroll the Member from Contractor and enroll the Member with the originally intended contractor up to 60 days from the date of the erroneous Enrollment, and the CCO Payment to Contractor will be adjusted accordingly.
8. Contractor shall provide Enrollment validation as described in Exhibit B, Part 3, Section 7(d) of this Contract.
9. Contractor shall actively participate with DHS and OHA to transition dual eligible beneficiaries from partial CCO/FFS enrollment to CCO-A during dual passive enrollment initiative (DPEI).

**b. Disenrollment**

The requirements and limitations governing Disenrollments contained in 42 CFR 438.56 and OAR 410-141-3080, Disenrollment Requirements, apply to Contractor regardless of whether Enrollment is mandatory or voluntary, except to the extent that 42 CFR 438.56(c)(2)(i) is expressly waived by CMS.

- (1) An individual is no longer a Member for purposes of this Contract as of the effective date of the individual's Disenrollment from Contractor. As of that date, Contractor is no longer required to provide services to such individual by the terms of this Contract, unless the Member is hospitalized at the time of Disenrollment. In such an event, Contractor is responsible for inpatient Hospital services until discharge or until the Member's PCP determines that care in the Hospital is no longer Medically Appropriate. OHA will assume responsibility for other services not included in the Diagnosis Related Group (DRG) applicable to the hospitalization.
- (2) If Disenrollment occurs due to an illegal act which includes Member or Provider Medicaid Fraud, Contractor shall report to OHA Office of Payment Accuracy and Recovery, consistent with 42 CFR 455.13 by one of the following methods: Fraud hotline 1-888-FRAUD01 (1-888-372-8301); or Report fraud online at [https://apps.state.or.us/cf1/OPR\\_Fraud\\_Ref/index.cfm?act=evt.subm\\_web](https://apps.state.or.us/cf1/OPR_Fraud_Ref/index.cfm?act=evt.subm_web)
- (3) A Member may be Disenrolled from Contractor as follows:
  - (a) If requested orally or in writing by the Member or the Member Representative, OHA may Disenroll the Member in accordance with OAR 410-141-3080 for the following reasons:
    - (i) Without cause:
      - (A) OHP Clients auto-enrolled or manual-enrolled in error may change plans, if another plan is available, within 30 days of the Member's Enrollment; or
      - (B) Newly eligible Members may change plans, if another plan is available, within 12 months of their initial plan Enrollment or the date OHA send the member notice of the Enrollment, whichever is later; or
      - (C) A Member may request Disenrollment at least once every 12 months after initial Enrollment; or
      - (D) Members who are eligible for both Medicare and Medicaid and Members who are AI/AN beneficiaries may change plans or disenroll to fee-for-service at any time; or
      - (E) Upon Automatic Re-enrollment (e.g., a recipient who is automatically re-enrolled after being disenrolled, solely because he or she loses Medicaid eligibility for a period of 2 months or less), if the temporary loss of Medicaid eligibility has caused the Member to miss the annual Disenrollment opportunity; or
      - (F) Whenever the Member's eligibility is re-determined by OHA.



- (6) Contractor may not request Disenrollment of a Member solely for reasons related to:
  - a. An adverse change in the Member’s health status;
  - b. Utilization of health services;
  - c. Diminished physical, intellectual, developmental or mental capacity;
  - d. Uncooperative or disruptive behavior resulting from the Member’s special needs, a disability or any condition that is a direct result of their disability, unless otherwise specified in OHP Administrative Rule; or
  - e. Other reasons specified in OAR 410-141-3080.
- (7) The effective date of Disenrollment when requested by a Member will be the first of the month following OHA’s approval of Disenrollment. If OHA fails to make a Disenrollment determination by the first day of the second month following the month in which the Member files a request for Disenrollment, the Disenrollment is considered approved.
- (8) If OHA disenrolls a Member retroactively, OHA will recoup any CCO Payments received by Contractor after the effective date of Disenrollment. If the disenrolled Member was otherwise eligible for the OHP at the time of service, any services the Member received during the period of the retroactive Disenrollment may be eligible for fee-for-service payment under OHA rules.
- (9) 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 60 days from the date of Disenrollment.
- (10) Disenrollment required by adjustments in Service Area or Enrollment is governed by Exhibit B, Part 3, Section 6 of this Contract.

**c. Member Benefit Package Changes**

The weekly and monthly enrollment file (as described in Exhibit B, Part 3, Section 6.d of this Contract) will identify Member’s current eligibility status. The file does not include any historical data on Member’s eligibility status.

**d. Enrollment Reconciliation**

- (1) Contractor shall reconcile the OHA 834 monthly Enrollment transaction file, sent by OHA to Contractor monthly, to Contractor’s current Member information in its Health Information System (HIS) for the same period (for purposes of this report refer to the previous month’s data) which is known as a “look back period”.
- (2) Contractor shall report to OHA Enrollment Reconciliation Coordinator via secure email, using the Enrollment Reconciliation Certification Forms, which are available on the Contract Reports Web Site. Contractor’s determination of OHA 834 monthly Enrollment transaction files shall be reported as follows:
  - (a) If there are no discrepancies, Contractor shall complete, sign, date and submit “Enrollment Reconciliation Certification- No Discrepancies”, to OHA Enrollment Reconciliation Coordinator within 14 days of receipt of the OHA 834 monthly Enrollment transaction file, or
  - (b) If there are discrepancies, Contractor shall complete, sign, date and submit, “Enrollment Reconciliation Certification - Discrepancies Found”, to OHA

Enrollment Reconciliation Coordinator within 14 days of receipt of OHA’s monthly Enrollment transaction file.

- (3) OHA will verify, and if applicable, correct all discrepancies reported to OHA on “Enrollment Reconciliation - Discrepancies Found”, prior to the next monthly Enrollment transaction file.

## 7. Identification Cards

Contractor shall provide an identification card to Members which contains simple, readable and usable information on how to access care in an urgent or emergency situation consistent with OAR 410-141-3300. 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.

## 8. Marketing to Potential Members

- a. Contractor shall apply the prohibitions of this paragraph to its agents, delegated entities, Subcontractors, and Subcontractor’s agents.
- b. Contractor and its Subcontractor’s communications that express participation in or support for the Contractor by its founding organizations or its Subcontractors shall not constitute an attempt to compel or entice a Potential Member’s enrollment
- c. Contractor has sole accountability for producing or distributing Marketing Materials following OHA approval.
- d. Contractor shall ensure that Potential Members are not intentionally misled about their options by Contractor’s staff, activities or materials. Contractor’s materials may not contain inaccurate, false, confusing or misleading information.
- e. Contractor shall provide copies of all written Marketing Materials to all DHS and OHA offices within Contractor’s Service Area. Pursuant to 42 CFR 438.104(b)(2), Contractor shall make no assertion or statement (whether written or oral) that:
  - (1) The Potential Member must enroll with Contractor in order to obtain benefits or not to lose benefits; or
  - (2) The Contractor is endorsed by CMS, the federal or State government, or similar entity.
- f. Contractor shall comply with the information requirements of 42 CFR 438.10, 438.100 and 438.104 to ensure that prior to enrollment, the Potential Member receives from the Contractor the accurate oral and written information the Potential Member needs to make an informed decision on whether to enroll with the Contractor. In doing so, the Contractor shall:
  - (1) Not distribute any Marketing Materials without first obtaining OHA approval;
  - (2) Distribute the Marketing Materials to its entire Service Area as indicated in this Contract;
  - (3) Not seek to compel or entice Enrollment in conjunction with the sale of or offering of any private insurance; and
  - (4) Not directly or indirectly engage in door to door, emailing, texting, telephone or Cold Call Marketing activities; and
- g. Contractor shall comply with OHA Materials Submission and Approval Form. The form is located at on the Contract Reports Web Site. Submission of the form goes to [OHP.Materials@state.or.us](mailto:OHP.Materials@state.or.us).

- h.** OHA will develop guidelines through a transparent public process, including input from Contractor and other stakeholders. The guidelines will include, but are not limited to:
  - (1) A list of communication or Outreach Materials subject to review by OHA;
  - (2) A clear explanation of OHA’s process for review and approval of Marketing Materials;
  - (3) A process for appeals of OHA’s edits or denials;
  - (4) A Marketing Materials submission form to ensure compliance with PHP Marketing rules; and
  - (5) An update of plan availability information submitted to the OHA on a monthly basis for review and posting.

**9. Member Communications**

- a.** Contractor is responsible for preparing a Member handbook to provide informational materials and Member education. Mailing of Member handbooks shall occur within 14 calendar days of receiving OHA’s initial 834 listing of Member’s enrollment (or re-enrollment after not being enrolled for 90 days or more) with the Contractor; however Contractor may deliver the Member handbook electronically if the Member has requested or approved electronic transmittal consistent with Exhibit B, Part 3, Section 2.q. and r. of the CCO Contract. Contractor shall notify all existing Members of each revision and its location on Contractor’s website, and offer to send the Member a printed copy on request. Contractor’s Member handbook shall incorporate all of the elements included in the Review Tool in the Appendix to this Exhibit.
- b.** For each item listed in the Review Tool, the column labeled “Text Provided by OHA or Contractor” describes whether OHA or the Contractor is responsible for developing the text. OHA will provide OHA text which may be modified and completed as needed for accuracy, and the CCO will develop the text for items identified on the tool as “Text Provided by Contractor.” Contractor shall compile a Member handbook in each prevalent language for the Members who speak those languages.
- c.** If Contractor chooses to provide required Member information electronically, the information must be placed in a prominent and readily accessible location on their website, can be electronically retained and printed. The information must be available in paper form, within 5 days, without charge upon request.
- d.** The Contractor shall review the Member handbook for accuracy at least yearly, updating with new or corrected information as needed to reflect the Contractor’s internal changes and any regulatory changes. Contractor shall submit each version of the CCO handbook to OHP.Materials@state.or.us for OHA approval initially and upon revision or upon OHA request. Compliance with the Review Tool does not replace the Contractor’s obligation to satisfy all the requirements of OAR 410-141-3300; it is just a tool for organizing review.

## **Exhibit B –Statement of Work - Part 4 – Providers and Delivery System**

### **1. Integration and Coordination**

Contractor shall develop, implement and participate in activities supporting a continuum of care that integrates behavioral health, oral health and physical health interventions seamlessly and holistically, including new member screenings. Contractor understands and acknowledges that integrated care spans a continuum ranging from communication to coordination to co-management to co-location to the fully integrated PCPCH.

Contractor shall conduct an initial health risk screening of each new Member's needs within 30 days of enrollment or within 10 days when the member is referred or within 30 days when the member is referred or is receiving Medicaid LTC or LTSS, or as quickly as the member's health condition requires. Contractor shall maintain documentation on the health risk screening process used for compliance. If the health risk screening requires additional information from the member, Contractor shall document all attempts to reach the member by telephone and mail, including subsequent attempts, to demonstrate compliance.

- a.** Contractor shall ensure, and shall implement procedures to ensure, that in coordinating care, the Member's privacy is protected consistent with the confidentiality requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable, and consistent with other State law or federal regulations governing privacy and confidentiality of health records.
- b.** Contractor shall demonstrate involvement in integration activities such as, but not limited to:
  - (1)** Enhanced communication and coordination between Contractor and oral health care Providers, and behavioral health Providers;
  - (2)** Implementation of integrated Prevention, Early Intervention and wellness activities;
  - (3)** Development of infrastructure support for sharing information, coordinating care and monitoring results;
  - (4)** Use of screening tools, treatment standards and guidelines that support integration;
  - (5)** Support of a shared culture of integration across CCOs and service delivery systems; and
  - (6)** Implementation of a System of Care approach, incorporating models such as the Four Quadrant Clinical Integration Model of the National Council for Community Behavioral Healthcare or Wraparound for children with Behavioral Health disorders.
- c.** Contractor shall coordinate the services the Contractor furnishes its Members with the services the Member receives from any other MCO, PIHP or PAHP to avoid duplication of services, as required by 42 CFR §438.208 (b)(2) and (5).
- d.** Contractor shall include the Oregon State Public Health Laboratory (OSPHL) as one of the in-network laboratory providers in their networks. Contractor shall reimburse the OSPHL for communicable disease testing laboratory services provided for enrolled members at the rate of the current Medicaid fee schedule for the date of service. The lists of laboratory tests provided by the OSPHL is posted at [www.healthoregon.org/labtests](http://www.healthoregon.org/labtests). This list is subject to change.

### **2. Access to Care**

Contractor shall provide culturally responsive and linguistically appropriate services and supports, in locations as geographically close as possible, to where Members reside or seek services and choice of Providers (including physical health, behavioral health, providers treating Substance Use Disorders, and

oral health) 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 Providers to meet, OHP standards for timely access to care and services, taking into account the urgency of need for services. Contractor shall comply with OAR 410-141-3220 and 410-141-3160. Contractor shall make Covered Services available 24 hours a day, 7 days a week, when medically appropriate.
- b.** Routine oral health care the Member shall be seen within eight weeks, unless there is a documented special clinical reason which would require longer access time. Pregnant women shall be provided oral health care according to the timelines outlined in 410-123-1510.
- c.** Contractor shall ensure that Providers do not discriminate between Members and non-OHP persons as it relates to benefits and services to which they are both entitled and shall ensure that Providers offer hours of operation to Members that are no less than those offered to non-Members as provided in OAR 410-141-3220.
- d.** Contractor shall provide each Member with an opportunity to select an appropriate Behavioral Health Practitioner and service site.
- e.** Contractor may not deny Covered Services to, or request Disenrollment of, a Member based on disruptive or abusive behavior resulting from symptoms of a mental or Substance Use Disorders or from another disability. Contractor shall develop an appropriate Treatment Plan with the Member and the Family or advocate of the Member to manage such behavior.
- f.** Contractor shall implement mechanisms to assess each Member with Special Health Care needs in order to identify any ongoing special conditions that require a course of physical health, behavioral health services, or care management. The assessment mechanisms must use appropriate health care professionals.
  - (1)** For Members with Special Health Care Needs determined to need a course of treatment or regular care monitoring, the Intensive Care Coordination Plan (ICCP), must be developed by Member's Intensive Care Coordinator with Member participation and in consultation with any specialists caring for the Member; approved by Contractor in a timely manner and revised upon assessment of function need or at the request of the Member, at least every 3 months for members receiving ICC services and every 12 months for other members, if approval is required; and developed in accordance with any applicable OHA quality assessment and performance improvement and Utilization Review standards.
  - (2)** Based on the Assessment, Contractor shall assist Members with Special Health Care Needs in gaining direct access to Medically Appropriate care from physical health or behavioral health specialists for treatment of the Member's condition and identified needs including the assistance available through intensive care coordinators if appropriate.
  - (3)** Contractor shall implement procedures to share with Member's Primary Care Provider the results of its identification and Assessment of any Member with Special Health Care Needs so that those activities are not duplicated. Contractor's procedures shall also require that the Member's assessment information be shared with other prepaid managed care health services organizations serving the Member. Such coordination and sharing of information must be conducted within federal and State laws, rules, and regulations governing confidentiality.

- g.** Contractor shall comply with the requirements of Title II of the Americans with Disabilities Act and Title VI of the Civil Rights Act by assuring communication and delivery of Covered Services to Members who have difficulty communicating due to a disability or limited English proficiency or diverse cultural and ethnic backgrounds, and shall maintain written policies, procedures and plans in accordance with the requirements of OAR 410-141-3220.
- h.** Contractor shall comply with the requirement of Title II of the Americans with Disabilities Act by providing services to Members with disabilities in the most integrated setting appropriate to the needs of those Members.
- i.** Contractor shall ensure that its employees, Subcontractors and facilities are prepared to meet the special needs of Members who require accommodations because of a disability or limited English proficiency. Contractor shall include in its Grievance and Appeal procedures, described in Exhibit I, a process for Grievances and Appeals concerning communication or access to Covered Services or facilities.
- j.** In addition to access and Continuity of Care standards specified in the rules cited in Subsection a, of this section, Contractor shall develop a methodology for evaluating access to Covered Services as described in Exhibit G and Continuity of Care which are consistent with the Accessibility requirements in OAR 410-141-3220.
- k.** Contractor shall ensure that each Member has an ongoing source of primary care appropriate to the Member's needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished as described in OAR 410-141-3120 and required by 42 CFR 438.208 (b)(1) and (2).
- l.** Contractor shall allow each AI/AN Member enrolled with Contractor to choose an Indian Health Care Provider as the Member's PCP if:

  - (1)** An Indian Health Care Provider is participating as a PCP within the Provider Network; and
  - (2)** The AI/AN Member is otherwise eligible to receive services from such Indian Health Care Provider; and
  - (3)** The Indian Health Care Provider has the capacity to provide primary health care services to such Members.
- m.** Contractor shall provide female Members with direct access to women's health specialists within the Provider Network for Covered Services necessary to provide women's routine and preventive health care services. This is in addition to the Member's designated PCP if the designated PCP is not a women's health specialist.
- n.** Contractor shall provide for a second opinion from a qualified Participating Provider, which may include a qualified mental health Participating Provider if appropriate, to determine Medically Appropriate services. If a qualified Participating Provider cannot be arranged then Contractor shall arrange for the Member to obtain the second opinion from a Non-Participating Provider, at no cost to the Member.
- o.** To effectively integrate and coordinate health care and care management for Fully Dual Eligible Members, Contractor shall demonstrate its ability to provide Medicare benefits to Fully Dual Eligible Members through one or more Medicare Advantage plans that is owned by, affiliated with, or contracted by the Contractor.

### **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 Panel that is supported with written agreements (as specified in Exhibit D, Section 18 and Exhibit B, Part 4, Section 10), and has sufficient capacity and expertise to provide adequate, timely and Medically Appropriate access to Covered Services, as required by this Contract and OHA rules, to Members across the age span from child to older adult, including Members who are Fully Dual Eligible.
- (2)** Contractor shall ensure members have access to a provider network that meets the needs of its members and potential members. Contractor shall contract with an appropriate number of providers to ensure member access to a full continuum of behavioral health, physical, and oral health services throughout the 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 Panel, Contractor shall develop and implement a methodology to establish and monitor network provider capacity based on at a minimum, the following factors:
  - (a)** The anticipated Medicaid Enrollment and anticipated Enrollment of Fully Dual Eligible individuals;
  - (b)** An appropriate range of preventive and specialty services for the population enrolled or expected to be enrolled in the Service Area;
  - (c)** The expected utilization of Services, also taking into consideration the oral, physical and behavioral health care needs of Members;
  - (d)** The number and types (in terms of training, experience, and specialization) of Providers required to provide services under this Contract;
  - (e)** The geographical location of Participating Providers and Members considering distance, travel time, the means of transportation ordinarily used by Members and whether the location provides physical access for Members with disabilities;
  - (f)** Data collected from Contractor’s grievance and appeal system;
  - (g)** Data collected from Contractor’s monitoring of member wait time to appointment;
  - (h)** Any deficiencies in network adequacy or access to services identified through the course of self-audit, reviews conducted by OHA’s contracted EQRO, monitoring 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 414.645;
  - (j)** The number of Providers who are not accepting new Members; and
  - (k)** The number of members assigned to PCPCHs.
- (3)** Contractor shall report on its Delivery System Network (DSN), identifying all individual providers and facilities that hold written agreements with Contractor to provide services to its members, including an appropriate range of preventive, primary care, behavioral

health, oral health, and other specialty services, sufficient in number, mix and geographic distribution to meet Member needs, using Exhibit G.

- (4) Contractor shall allow each Member to choose a Provider within the Provider Network to the extent possible and appropriate.
- (5) Contractor shall coordinate its service delivery system with organized planning efforts carried out by the local mental health authority in its Service Area.
- (6) Contractor shall contract with a sufficient number of Substance Use Disorders residential treatment facilities to ensure timely access to Covered Services.
- (7) Contractor shall ensure that its Participating Providers contract with facilities that can meet cultural responsiveness and linguistic appropriateness, the needs of adolescents, parents with dependent children, pregnant women, IV drug users and Members with medication assisted therapy needs.

#### **4. Provider Workforce Development**

- a. Contractor shall provide a report to OHA at the beginning of CY 2020 and each contract year thereafter, describing the members in the Contractors network, its current oral, behavioral, and physical health provider workforce in Contractor's region, and the plan to meet member's oral, behavioral, and physical health care needs.
- b. Contractor shall utilize data from Contractor's relevant reports on workforce capacity and diversity to inform Contractor's workforce development strategies.
- c. Contractor shall dedicate a portion of its workforce development efforts and investments towards Traditional Health Workers based on the needs of Contractor's members and overall provider network.
- d. Contractor shall demonstrate that the number of Indian Health Care Providers that are Participating Providers is sufficient to ensure timely access to Covered Services within the scope of Covered Services specified under this Contract, for those AI/AN enrolled with the Contractor who are eligible to receive services from such Providers or shall demonstrate that there are few Indian Health Care Providers or that none exist in Contractor's Service Area.
- e. Contractor shall promote the delivery of services in a culturally responsive manner to Members, including those with limited English proficiency and diverse cultural and ethnic backgrounds.
- f. Contractor shall identify training needs of its Provider Network and shall address such needs to improve the ability of the Provider Network to deliver Covered Services to Members.
- g. Contractor shall require and provide training or ensure training is provided on implicit bias for all of Contractor's staff and provider network as described in Exhibit N.
- h. If Contractor is unable to provide any necessary Covered Services which are culturally responsive and linguistically and Medically Appropriate to a particular Member within its Provider Panel, Contractor shall adequately and timely cover these services out of network for the Member, for as long as Contractor is unable to provide them. Non-Participating Providers must coordinate with Contractor with respect to payment. Contractor shall ensure that cost to Member is no greater than it would be if the services were provided within the Provider Panel.

#### **5. Provider Selection**

Contractor shall establish written policies and procedures that comply with credentialing and re-credentialing requirements outlined in OAR 410-141-3120, the requirements specified in 42 CFR

438.214, which include selection and retention of Providers, and nondiscrimination provisions. In establishing and maintaining the network, Contractor shall:

- a. Complete the DSN Provider Report as required in Exhibit G and submit to the OHA Contract Administration Unit no later than 30 days following the end of each quarter. Contractor shall update its DSN Provider Report at any time there has been a change in Contractor's operations that would impact provider capacity and the availability of services, including changes in services, benefits, Service Area or payments or the Enrollment of a new population or any time it enters into a contract with OHA;
- b. Use Provider selection policies and procedures, in accordance with 42 CFR 438.12 and 42 CFR 438.214, that do not discriminate against Providers that serve high-risk populations or who specialize in conditions that require costly treatment. If Contractor declines to include individual or groups of Providers in its Provider Network, it must give the affected Providers written notice of the reason for its decision;
- c. Provide a dispute resolution process, including the use of an independent third party arbitrator, for a Provider's refusal to contract with Contractor or for the termination, or non-renewal of a Provider's contract with Contractor, pursuant to OAR 410-141-3269.
- d. Provide a written justification for Contractor's refusal to contract with a Provider or groups of Providers, and make Contractor's provider selection policy available to the Provider when Contractor declines to contract;
- e. Assure that Traditional Health Workers, who are employed by Contractor or subcontractors, have met the requirements for background checks for Traditional Health Workers, as described in OAR 410-180-0326;
- f. Terminate its contract with a provider immediately upon notification from the State that a provider may not be enrolled as a Medicaid Provider; and
- g. Apply the same credentialing and enrollment criteria required of providers enrolling with OHA as Fee for Service providers.

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 provider contracts pending the outcome of screening and enrollment with OHA, for no longer than 120 days, and shall terminate the contract immediately if notified by OHA that the Provider cannot be enrolled. Contractor may not execute provisional provider contracts with moderate or high-risk providers subject to fingerprint-based background checks until the provider has been approved for enrollment by OHA

## **6. Credentialing**

- a. Contractor shall have written policies and procedures for collecting evidence of credentials, screening the credentials, reporting credential information and recredentialing of Participating Providers including acute, primary, dental, behavioral, substance use disorder providers and facilities used to deliver Covered Services, consistent with PPACA Section 6402, 42 CFR§ 438.214, 42 CFR §455.400-455.470 (excluding 455.460), OAR 410-141-3120 and Exhibit G, except as provided in Subsection b, of this Section. These procedures shall also include collecting proof of professional liability insurance, whether by insurance or a program of self-insurance.
- b. When credentialing Providers or provider types designated by CMS as "moderate" or "high-risk", Contractor shall provide to OHA at the time of enrollment documentation that demonstrates the Provider has undergone a fingerprint-based background check and site visit

- within the previous 5 years. For a Provider that is actively enrolled in Medicare and has undergone a fingerprint-based background check as part of Medicare enrollment, this will be deemed to satisfy the requirement for OHA provider enrollment.
- c.** Contractors shall ensure Telemedicine credentialing requirements are consistent with OAR 410-130-0610.
  - d.** If Participating Providers (whether employees or Subcontractors) are not required to be licensed or certified by a State of Oregon board or licensing agency, Contractor shall document, certify and report on Exhibit G the date that the person’s education, experience, competence, and supervision are adequate to permit the person to perform his or her specific assigned duties.
    - (1)** If Participating Providers are not required to be licensed or certified by a State of Oregon board or licensing agency, then:
      - (a)** Participating Providers must meet the definitions for QMHA (qualified mental health associate) or QMHP (qualified mental health professional) as described in Exhibit A, Definitions and provide services under the supervision of a LMP (licensed medical practitioner) as defined in Exhibit A, Definitions; or
      - (b)** For Participating Providers not meeting either the QMHP or QMHA definition, Contractor shall document and certify that the person’s education, experience, competence, and supervision are adequate to permit the person to perform his or her specific assigned duties.
    - (2)** If programs or facilities are not required to be licensed or certified by a State of Oregon board or licensing agency, then the Contractor shall obtain documentation from the program or facility that demonstrates accreditation by nationally recognized organizations recognized by the OHA for the services provided (e.g., Council on Accredited Rehabilitation Facilities (CARF), or The Joint Commission (TJC) where such accreditation is required by OHA rule to provide the specific service or program.
  - e.** Contractor shall not discriminate with respect to participation, reimbursement or indemnification as to any Provider who is acting within the scope of the Provider’s license or certification as specified in 42 CFR §438.12 and under OAR 410-141-3120 on the basis of such license or certification. If Contractor declines to include individual or groups of Providers in its Provider Network, it must give written notice of the reason for its decision. This paragraph does not:
    - (1)** Prohibit Contractor from including Providers only to the extent necessary to meet the needs of Members;
    - (2)** Require that Contractor contract with any health care Provider willing to abide by the terms and conditions for participation established by the Contractor;
    - (3)** Preclude Contractor from establishing varying reimbursement rates based on quality or performance measures consistent with Contractor’s responsibilities under this Contract; or
    - (4)** Preclude Contractor from using different reimbursement amounts for different specialties or for different Practitioners in the same specialty.
  - f.** Contractor shall maintain records documenting academic credentials, training received, licenses or certifications of staff and facilities used, and reports from the National Practitioner Data Bank and must provide accurate and timely information about license or certification expiration and renewal dates to the OHA. Contractor may not refer Members to or use Providers who do not have a valid license or certification required by state or federal law. If Contractor knows or has

reason to know that a Provider’s license or certification is expired or not renewed or is subject to licensing or certification sanction, the Contractor must immediately notify OHA’s Provider Services Unit.

- g.** Contractor may not refer Members to or use Providers who have been terminated from OHA or excluded as Medicare, CHIP or Medicaid Providers by CMS or who are subject to exclusion for any lawful conviction by a court for which the Provider could be excluded under 42 CFR §1001.101 and 42 CFR §455.3(b). Contractor may not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act and in accordance with 42 CFR §438.214(d). Contractor may not accept billings for services to Members provided after the date of the Provider’s exclusion, conviction, or 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”), the Contractor must immediately notify OHA’s Provider Services Unit.
- h.** Contractor may not pay for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) in the following:

  - (1)** Furnished under the plan by any individual or entity during any period when the individual or entity is excluded from participation under title V, XVIII, or XX or pursuant to section 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act, and when the person furnishing such item or service knew, or had reason to know, of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person), as stated in section 1903(i)(2)(B) of the Social Security Act.
  - (2)** Furnished by an individual or entity to which OHA has failed to suspend payments during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless OHA determines there is good cause not to suspend such payment, as stated in section 1903(i)(2)(C) of the Social Security Act.
  - (3)** With respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997, as stated in section 1903(i)(16) of the Social Security Act.
  - (4)** For home health care services provided by an agency organization, unless the agency provides OHA with the surety bond specified in Section 1861(o)(7) of the Social Security Act, as stated in section 1903(i)(18) of the Social Security Act.
- i.** Only registered National Provider Identifiers (NPIs) and taxonomy codes reported to the OHA in the DSN Provider Capacity Report may be used for purposes of encounter data submission, prior to submitting encounter data in connection with services by the Provider.
- j.** Contractor shall require each Physician and other qualified Provider to have a unique provider identification number that complies with 42 USC 1320d-2(b).
- k.** Contractor shall provide training for Contractor staff and Participating Providers and their staff regarding the delivery of Covered Services, applicable administrative rules, and the Contractor’s administrative policies.

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

- a.** Contractor shall include in its network, to the greatest extent possible, Patient-Centered Primary Care Homes as identified by OHA. Contractor shall develop and assist in advancing Providers

along the spectrum of the PCPCH model (from Tier 1 to Tier 5). Contractor shall assist Providers within its delivery system to establish PCPCHs.

- b.** In addition to Provider reporting requirements described in OARs, Contractor shall provide a report to OHA Contract Administration Unit, no later than 30 days following the end of each quarter, to include all Members that are assigned to a PCPCH Provider listed out by tier 1, 2, 3, 4 or 5. Contractor shall coordinate with each PCPCH Provider in developing these lists.
- c.** Contractor shall require its Providers to communicate and coordinate care with the PCPCH in a timely manner using electronic health information technology to the maximum extent feasible.
- d.** Contractor shall develop and use PCPCH and other patient-centered primary care approaches to achieve the goals of Health System Transformation.
- e.** In this connection, Contractor shall contract with a network of PCPCHs recognized under Oregon’s standards (OAR 409-055-0000 to 0090). Contractor shall provide:
  - (1)** A work plan for increasing the number of enrollees served by certified PCPCHs over the first five years of operation, including targets and benchmarks; and
  - (2)** A concrete plan for Tier 1 PCPCHs to move toward Tier 2 and 3 of the Oregon standard over the first five years of operation, including targets and benchmarks.
- f.** Contractor shall ensure that Members of all communities in its Service Area receive integrated, culturally responsive and linguistically appropriate person-centered care and services, and that Members are fully informed partners in transitioning to and maximizing the benefits of this model of care.
  - (1)** Contractor shall encourage the use of FQHCs, rural health clinics, school-based health clinics and other safety net Providers that qualify as PCPCHs to ensure the continued critical role of those Providers in meeting the health of underserved populations.
  - (2)** Contractor shall negotiate a rate of reimbursement with Fully Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) that is not less than the level and amount of payment which the Contractor would make for the same service(s) furnished by a Provider which is not a FQHC or RHC, consistent with the requirements of 42 USC §1396b (m)(2)(A)(ix) and BBA 4712(b)(2);
  - (3)** Contractor shall offer contracts to all Medicaid eligible IHCPs in the area they serve and provide access to specialty and primary care within their networks to CCO-enrolled Indian Health Services beneficiaries seen and referred by IHCPs, regardless of the IHCPs status as contracted provider within the Contractor’s network.
  - (4)** The Contractor must adopt the CMS “Model Medicaid and Children’s Health Insurance Program (CHIP) Managed Care Addendum for Indian Health Care Providers (IHCPs)” (Model IHCP Addendum in CCO Forms webpage) or an addendum agreed upon in writing by the Contractor and every tribe and Indian Health Care Provider (IHCP) in the Contractor’s region. IHCPs may agree to include additional provisions in the Model IHCP Addendum.
  - (5)** Contractors and IHCPs interested in entering into a contract will reach an agreement on the terms of the contract within six months of expression of interest or initial discussion between the CCO and IHCP, unless an extension is agreed upon by both parties.

- (a) If the Contractor and IHCP do not reach an agreement on the terms of the contract within six months, the IHCP may request the assistance of a state representative to assist with negotiation of the contract.
- (b) The state will use an informal process to facilitate an in-person meeting with the Contractor and IHCP to assist with the resolution of issues.
- (c) If an informal process does not lead to an agreement, the Contractor and IHCP will use the existing dispute resolution process described in OAR 410-141-3269. The informal process shall be used as guidance and will not be binding.
- (d) Upon agreement of terms as addresses in (1)(b), Contractor and IHCP must finalize and approve the contract within 90 days of reaching an agreement.

## 8. Care Coordination

Contractor shall provide following elements of care coordination:

- a. Contractor shall support the appropriate flow of relevant information; identify a lead Provider or primary care team to manage Member care and coordinate all Member services; and, in the absence of full health information technology capabilities, implement a standardized approach to effective transition planning and follow-up.
- b. Contractor shall work with Providers to develop the partnerships necessary to allow for access to and coordination with social and support services, including culturally specific community-based organizations, community based mental health services, DHS Medicaid-funded long term care services and mental health crisis management services.
- c. Contractor shall develop culturally responsive and linguistically appropriate tools for Provider use to assist in the education of Members about roles and responsibilities in communication and care coordination.
- d. Contractor shall coordinate with DHS Medicaid-funded long term care Providers and Type B AAAs or State APD district offices in its Service Area for their Members receiving DHS Medicaid-funded long term care services.
- e. Contractor shall document and submit no later than June 30<sup>th</sup> an update of coordination activities through Memoranda of Understanding (MOU), or subcontractual arrangement(s) between the Contractor and the Type B AAA or State APD district office(s) in its Service Area. The APD MOU guidance document can be found at <http://www.oregon.gov/DHS/SENIORS-DISABILITIES/LTC/Pages/HST-APD-CCO.aspx> MOUs will be reviewed by DHS-APD and OHA and feedback will be given to Contractor.
- f. Contractor shall coordinate with residential behavioral health services Providers, including Providers outside of Contractor's Service Area, for their Members receiving both Medicaid-funded and non-Medicaid-funded residential addictions and mental health services.
- g. Contractor shall coordinate with the Oregon State Hospital, state institutions and other mental health hospital settings to facilitate Member transition into the most appropriate, independent, and integrated community-based settings.
- h. Contractor shall use evidence-based and innovative strategies within Contractor's delivery system to ensure coordinated and integrated person-centered care for all Members, including those with severe and persistent mental illness or other chronic conditions who receive home and community based services under the State's 1915(i) State Plan Amendment, as follows:

- (1) Assignment of responsibility and accountability: Contractor shall document that each Member has a PCP or primary care team that is responsible for coordination of care and transitions.
- (2) Individual care plans: Contractor shall use individualized care plans to address the supportive and therapeutic and cultural and linguistic health of each Member, particularly those with intensive care coordination health needs. Contractor shall ensure that individual care plans developed for Members reflect Member, Family or caregiver preferences and goals to ensure engagement and satisfaction.
- (3) Communication: Contractor shall encourage and work with their Providers to develop the tools and skills necessary to communicate in a culturally responsive and linguistically appropriate fashion.

## **9. Care Integration**

**a.** Contractor shall ensure the provision of the following elements of Care Integration:

- (1) Mental Health and Substance Use Disorders Treatment: Outpatient behavioral health treatment shall be integrated into a person-centered care delivery system and coordinated with physical health care services by Contractor and by Contractor's transformed health system.
- (2) Oral Health: Contractor shall provide adequate and appropriate access to dental providers for oral health services.
- (3) Hospital and Specialty Services: Contractor shall provide adequate, timely and appropriate access to specialty and Hospital services. Contractor's service agreements with specialty and Hospital Providers shall address the coordinating role of patient-centered primary care; shall specify processes for requesting Hospital admission or specialty services; and shall establish performance expectations for communication and medical records sharing for specialty treatments, at the time of Hospital admission or discharge, for after-Hospital follow up appointments. Contractor shall demonstrate how Hospitals and specialty service providers are accountable for achieving successful transitions of care. Contractor shall ensure that primary care teams transition Members out of Hospital settings into the most appropriate, independent, and integrated care settings, including home and community-based as well as Hospice and other palliative care settings.

**b.** Contractor shall ensure documentation of the following features of the delivery system:

- (1) Each Member has access to a consistent and stable relationship with a primary care team that is responsible for comprehensive care management and transitions.
- (2) The supportive and therapeutic needs of the Member are addressed in a holistic fashion, using patient centered primary care homes and individualized care plans to the extent feasible.
- (3) Members receive comprehensive transitional care, including appropriate follow-up, when entering and leaving an acute care facility or a long term care setting.
- (4) Members receive assistance in navigating the health care delivery system and in accessing community and social support services and statewide resources.
- (5) Members have access to advocates such as Traditional Health Workers who may be part of the Member's primary care team.

- (6) Members are encouraged within all aspects of the integrated and coordinated health care delivery system to use wellness and prevention resources and to make healthy lifestyle choices.

## 10. Delivery System Dependencies

### a. Intensive Care Coordination for Prioritized Populations and Special Health Members

- (1) Contractor shall prioritize working with Members who have high health care needs, multiple chronic conditions, mental illness or Substance Use Disorders and communities experiencing health disparities (as identified in the community health assessment). Contractor shall actively engage those Members in accessing and managing appropriate preventive, remedial and supportive care and services to reduce the use of avoidable emergency room visits and Hospital admissions.
- (2) Contractor shall provide Intensive Care Coordination services to Members who are aged, blind, disabled or who have complex medical needs, consistent with ORS 414.712, including Members with mental illness and Members with severe and persistent mental illness receiving home and community-based services under the State's 1915(i) State Plan Amendment.
- (3) Contractor shall implement procedures to share the results of its identification and Assessment of any Member identified as aged, blind, disabled (including mental illness or substance abuse disorders) or having complex medical health needs with Participating Providers serving the Member so that those activities need not be duplicated. Contractor shall create procedures and share information under ORS 414.679 in compliance with the confidentiality requirements of this Contract.
- (4) Contractor shall establish a system supported by written policies and procedures, for identifying, assessing and producing a Treatment Plan for each Member identified as having a special healthcare need, including a standing referral process for direct access to specialists. Contractor shall ensure that each Treatment Plan:
  - (a) Is developed by the Member's designated Practitioner with the Member's participation;
  - (b) Includes consultation with any specialist caring for the Member;
  - (c) Is approved by the Contractor in a timely manner, if this approval is required; and
  - (d) Accords with any applicable State quality assurance and Utilization Review standards.

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

Contractor shall promote communication and coordination with state and local government agencies and culturally diverse community social and support services organizations, including early child education, special education, Behavioral Health and public health, as critical for the development and operation of an effective delivery system. Contractor shall consult and collaborate with its Providers to maximize Provider awareness of available resources to ensure diverse Members' health, and to assist Providers in referring Members to the appropriate Providers or organizations. Contractor shall ensure that the assistance provided regarding referrals to State and local governments and community social and support services organizations takes into account the referral and service delivery factors identified in the Community Health Assessment and Community Improvement Plan.

**c. Cooperation with Dental Care Providers**

Contractor shall coordinate preauthorization and related services between Physical and Dental Care Providers to ensure the provision of Dental Services to be performed in an outpatient Hospital or ASC in cases in which the age, disability, or medical condition of the Member necessitates providing services in an outpatient Hospital or ASC.

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

Contractor shall arrange to provide medication, as covered under Contractor's Global Budget, to nursing or residential facility and group or foster home residents in a format that is reasonable for the facility's delivery, dosage and packaging requirements and Oregon law.

**11. Evidence-Based Clinical Practice Guidelines**

Contractor shall adopt practice guidelines, specified in 42 CFR §438.236 (b), (c) and (d), that are based on valid and reliable clinical evidence or a consensus of healthcare professionals and that consider the needs of Members. Contractor shall adopt these practice guidelines in consultation with Contractor's Participating Providers and shall review and update them periodically as appropriate. Contractor shall disseminate the practice guidelines to all affected Providers and, upon request, to Members, Potential Members or Member Representatives. Contractor's decisions for utilization management, Member education, coverage of services, or other areas, to which the guidelines apply, must be consistent with the adopted practice guidelines.

**12. Health Promotion and Prevention**

Contractor shall provide evidence-based care in a culturally responsive and linguistically appropriate manner that supports prevention, contains cost, and improves health outcomes and quality of life for their Members. Contractor shall report to OHA Contract Administration Unit on health promotion and disease prevention, describing the means by which Contractor will accomplish the following tasks. Contractor shall:

- a.** Collect data for Member population service planning and delivery, reported with consideration to implementing state plans for achieving public health objectives of eliminating racial and ethnic disparities and meeting national Healthy People 2020 objectives and Meaningful Use standards.
- b.** Provide culturally responsive and linguistically appropriate health risk assessment for Members. Assessment may be provided or coordinated through a Members' PCPCH. These assessments will include screening for chronic disease and risk factors such as alcohol, tobacco use and other substance use, high blood pressure, diabetes, depression, breast, colorectal and cervical cancer, high cholesterol, stress, trauma and other mental health issues with opportunities for education, treatment and follow-up based on results.
- c.** Actively promote all health screening methodologies receiving a Grade A or B recommendation by the US Preventive Services Task Force to patients, families, and Providers.
- d.** Actively promote screenings recommended by Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents (4<sup>rd</sup> edition) (2017) for pediatric populations to patients, families, and Providers.
- e.** Demonstrate evidence of partnership with health promotion, racially, ethnically and linguistically diverse community, and local prevention leaders and professionals, including local public health authorities.
- f.** Contribute to the implementation of the State's comprehensive plans for promotion of physical activity and healthy nutrition, tobacco prevention and older adult and youth suicide prevention.

- g.** Contribute to local public health and health promotion planning efforts.
- h.** Meet the needs of culturally responsive and linguistically diverse communities and specify the actions Contractor will take to reduce or eliminate health disparities.
- i.** Disseminate culturally responsive and linguistically appropriate educational materials that meet Members diverse health literacy needs on healthy lifestyles and chronic disease early detection, treatment and self-management at plan and Provider levels (provider/hospital Meaningful Use optional criteria).
- j.** Assure full compliance with disease reporting to the public health system.
- k.** Coordinate the above activities with Members' Patient-Centered Primary Care Home or PCP.

### **13. Subcontract Requirements**

The requirements of this section do not prevent the Contractor from including additional terms and conditions in its subcontracts to meet the legal obligations or system requirements of the Contractor. Contractor shall ensure that the following standards are included in its Subcontracts:

#### **a. General Standards**

- (1)** Contractor shall ensure that all subcontracts are in writing, specify the subcontracted Work and reporting responsibilities, meet the requirements described below and any other requirement as described throughout this Contract, and incorporate portions of this Contract, as applicable, based on the scope of Work to be subcontracted. Contractor must evaluate the prospective Subcontractor's readiness and ability to perform the scope of work outlined in the written agreement prior to the effective date of the contract. Copies of the evaluation shall be provided to OHA any time Contractor enters into a new Subcontractor agreement.
- (2)** Contractor shall ensure that all Subcontractors are screened for exclusion from participation in federal programs, and is prohibited from contracting with any Subcontractor who is an excluded entity.
- (3)** Contractor shall ensure that all Subcontractors undergo a criminal background check prior to starting any work identified in this Contract.
- (4)** Some activities in this agreement may not be subcontracted and must be performed by the Contractor. Work that may not be subcontracted is identified as such throughout this contract. Subject to the provisions of this section, Contractor may subcontract any of the Work to be performed under this Contract that is not identified as an exclusion. No Subcontract may terminate or limit Contractor's legal responsibility to OHA for the timely and effective performance of Contractor's duties and responsibilities under this Contract. Any and all Corrective Action, Sanctions, recovery amounts and enforcement actions are solely the responsibility of the Contractor. Contractor retains all legal responsibility and may not delegate the responsibility for monitoring and oversight of subcontracted activities. Contractor retains responsibility for adhering to and otherwise fully complying with all terms and conditions of this contract.
- (5)** Contractor shall provide to OHA a list of any activities outlined in this contract that have been subcontracted using the Subcontractors and Delegated Entities Report template.
- (6)** The report should identify any activities Contractor has agreed to perform under this Contract that has been subcontracted or delegated, and include information related to the subcontracted work including:

- (a) The legal name of the Subcontractor;
  - (b) The scope of work being subcontracted;
  - (c) Copies of ownership disclosure form, if applicable;
  - (d) Copies of all written agreements with Subcontractors to ensure all contracts meet the requirements outlined in 42 CFR 438.230;
  - (e) Any ownership stake between Contractor and the Subcontractor.
- (7) Contractor shall provide this information in the Subcontractor and Delegated Entity Report no later than January 31<sup>st</sup> of each year, and shall notify OHA within 30 days any time there has been a change in subcontractor.
- (8) The following requirements of this Contract may not be subcontracted:
  - (a) Oversight and monitoring of Quality Improvement activities; and
  - (b) Adjudication of Appeals in a Member Grievance and Appeal process.
- (9) If deficiencies are identified in Subcontractor performance for any functions outlined in this contract, whether those deficiencies are identified by Contractor, by OHA or its designees, Contractor agrees to require its Subcontractor to respond and remedy those deficiencies within the timeframe determined by OHA.
- (10) Contractor shall ensure that Subcontractors and Providers do not bill Members for services that are not covered under this Contract unless there is a full written disclosure or waiver (also referred to as agreement to pay) on file signed by the Member, in advance of the service being provided, in accordance with OAR 410-141-0420.
- (11) Contractor shall provide every Provider or Subcontractor, at the time it enters into a contract or subcontract its OHA-approved written procedures for its Grievance System and ensure compliance with all federal and State requirements for member Grievance and Appeals.
- (12) Contractor shall monitor the Subcontractor's performance on an ongoing basis and perform at least once a year a formal review of compliance with delegated responsibilities and Subcontractor performance, deficiencies or areas for improvement, in accordance with 42 CFR 438.230(b)(1).
- (13) The review of Subcontractor performance and compliance 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.

- (14) Contractor shall provide OHA a copy of the compliance review within 30 days of completion. Contractor shall oversee and be responsible for the satisfactory performance of any functions or responsibilities it delegates to a subcontractor.
- (15) Upon identification of deficiencies or areas for improvement, Contractor shall cause Subcontractor to take Corrective Action and shall notify the Contract Administrator of the Corrective Action within 14 days.
- (16) Contractor shall provide to OHA a copy of the Corrective Action Plan documenting the deficiencies, the actions required of the Subcontractor to remedy the deficiencies, and the timeframe for completing the required actions.
- (17) Contractor shall update OHA on the status of the Corrective Action at such time that the Subcontractor has been successfully removed from Corrective Action or if the deadline for remedy has passed and the underlying deficiency has not been fully corrected.

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

- (1) Contractor's written agreement with the Subcontractor shall:
  - (a) Provide for the termination of the Subcontract or imposition of other Sanctions by Contractor if the Subcontractor's performance is inadequate to meet the requirements of this Contract;
  - (b) Provide for revocation of the delegation of activities or obligations, and specify other remedies in instances where OHA or the Contractor determine the subcontractor has not performed satisfactorily;
  - (c) Require Subcontractor to comply with the requirements of 42 CFR 438.6 that are applicable to the Work required under the subcontract;
  - (d) Require Subcontractor to submit Valid Claims for services including all the fields and information needed to allow the claim to be processed without further information from the Provider within timeframes for encounter data submission outlined in other sections of this contract;
  - (e) Specify that the Subcontractor agrees to comply with all applicable Medicaid laws, regulations, including applicable sub-regulatory guidance and contract provisions;
  - (f) Specify that the Subcontractor agrees that OHA, CMS, the HHS Inspector General or their designees 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 the CCO's Contract with OHA;
  - (g) Specify that the Subcontractor will make available, for purposes of audit, evaluation, or inspection its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems relating to its Medicaid Members;
  - (h) Specify that the Subcontractor must respond and comply in a timely manner to any 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 through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later; and
  - (j) Specify that if OHA, CMS, or the DHHS Inspector General determine that there is a reasonable possibility of fraud or similar risk, OHA, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the Subcontractor at any time.
- (2) Contractor shall provide Members written notice of termination of any Subcontractor, within 15 days after receipt or issuance of the termination notice, to each Member who received his or her primary care from, or was seen on a regular basis by, the terminated Subcontractor.
  - (3) Contractor shall meet, and require its Subcontractors and Participating Providers to meet, OHP standards for timely access to care and services, taking into account the urgency of the need for services as specified in OAR 410-141-3220. This requirement includes the Participating Providers offering hours of operation that are not less than the hours of operation offered to Contractor’s commercial Members (as applicable).
  - (4) Contractor shall notify OHA in writing within 30 days of terminating any Subcontractor and provide an updated Subcontractors and Delegated Entities Report. Contractor shall notify OHA in writing within 30 days of terminating any Participating Provider contract when such termination is a for-cause termination, including but not limited to the following:
    - (a) Failure to meet requirements under the contract;
    - (b) For reasons related to fraud, integrity, or quality;
    - (c) Deficiencies identified through compliance monitoring of the entity; or
    - (d) Any other for-cause termination.

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

- a. As noted in Oregon Executive Order 12-03: “Minority-owned and Woman-owned businesses continue to be a dynamic and fast-growing sector of the Oregon economy. Oregon is committed to creating an environment that supports the ingenuity and industriousness of Oregon’s Minority Business Enterprise [MBE] and Woman Business Enterprise [WBE]. Emerging Small Business [ESB] firms are also an important sector of the state’s economy.”
- b. Contractor shall take reasonable steps, such as through a quote, bid, proposal, or similar process, to ensure that MWESB certified firms are provided an equal opportunity to compete for and participate in the performance of any subcontracts under this Contract. If there may be opportunities for subcontractors to work on the Contract, it is the expectation of OHA that the Contractor will take reasonable steps to ensure that MWESB certified firms, as referenced on: <http://www.oregon4biz.com/how-we-can-help/COBID/>, are provided an equal opportunity to compete for and participate in the performance of any subcontracts under this Contract.

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

- a. If Contractor is engaged in the termination or loss of a Provider or group or affected by other factors which have significant impact on access in that Service Area and which may result in transferring a substantial number of Members to other Providers employed or subcontracted with

- Contractor, Contractor shall provide OHA with a written plan for transferring the Members and an updated DSN Provider Report, Exhibit G, at least 90 days prior to the date of such action.
- 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 with a written notice and a plan for implementation at least 90 days prior to the date of such action.
  - c.** OHA will not approve a transfer of Members if the Provider's contract with the transferring Contractor is terminated for reasons related to quality of care, competency, Fraud or other reasons described in OAR 410-141-3080.
  - d.** OHA reserves the right to waive the required notice period in certain circumstances, including but not limited to:
    - (1)** If Contractor must terminate a Provider or group due to circumstances that could compromise Member care;
    - (2)** If a Provider or group terminates its subcontract or employment with Contractor or if Contractor is affected by circumstances beyond Contractor's control and the Contractor cannot reasonably provide the required 90 day notice; or,
    - (3)** At OHA's discretion.
  - e.** OHA will reassign any transferring members to another Managed Care Plan 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 90 day period without limitation, for all Members for which the Contractor received a CCO Payment.
  - g.** If Members are required to disenroll from Contractor pursuant to this section, Contractor retains responsibility for providing access to all Covered Services, without limitation, for each Member until the effective date of Disenrollment. Unless specified otherwise by OHA, Disenrollments shall be effective the end of the month in which the Disenrollment occurs. 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 section. OHA may, in its discretion, withhold up to 20% of Contractor's monthly CCO Payment (subject to actuarial considerations) until all contractual obligations have been met to OHA's satisfaction. Contractor's failure to complete or ensure completion of said contractual obligations within a timeframe defined by OHA will result in a forfeiture of the amount withheld.
  - i.** If Contractor is assigned or transferred Clients pursuant to this section, Contractor accepts all assigned or transferred Clients without regard to the Enrollment exemptions in OAR 410-141-3060.
  - j.** If this Contract is amended to reduce the Service Area or the Enrollment limit, or both, OHA may recalculate the CCO Payment rates using the following methodology, as further described in Exhibit C:

If the calculation based on the reduced Service Area or Enrollment limit would result in a rate decrease, OHA may provide Contractor with an amendment to this Contract to reduce the amount of the CCO Payment rates in Exhibit C, Attachment 1, which (subject to CMS approval) will be effective the date of the reduction of the Service Area or Enrollment limit.

- k.** If this Contract is amended to expand the Service Area or the Enrollment limit, or both, OHA may recalculate the CCO Payment rates using the following methodology, as further described in Exhibit C:
- (1)** If the calculation based on the expanded Service Area or Enrollment limit would result in a rate increase, OHA may provide Contractor with an amendment to this Contract to increase the amount of the CCO Payment rates in Exhibit C, Attachment 1, 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.

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

## **Exhibit B –Statement of Work - Part 8 – Operations**

### **1. Accountability and Transparency of Operations**

- a.** Contractor shall adhere to any industry standards, and state and federal law in the management of finances, contracts, claims processing, payment functions and Provider Networks consistent with ORS 414.625.
- b.** Contractor shall provide, and require its Subcontractors to provide, timely access to records and facilities and cooperate with OHA in collection of information through consumer surveys, on-site reviews, medical chart reviews, financial reporting and financial record reviews, interviews with staff, and other information for the purposes of monitoring compliance with this Contract, including but not limited to verification of services actually provided, and for developing and monitoring performance and outcomes.
- c.** Contractor shall assist OHA with development and distribution of survey instruments and participate in other evaluation procedures defined by OHA for evaluating CCO progress on payment reform and delivery system change including the achievement of benchmarks, progress toward eliminating health disparities, results of evaluations, customer satisfaction, use of patient centered primary care homes, the involvement of local governments in governance and service delivery, or other developments as determined necessary by OHA, CMS or external review organizations.
- d.** Contractor shall ensure record keeping policies and procedures are in accordance with 42 CFR §438.3(u). Contractor shall keep documents specified in 42 CFR §438.5(c), 438.604, 438.606, 438.608 and 438.610 for no less than 10 years.
- e.** Contractor shall develop and maintain a record keeping system that:
  - (1)** Includes sufficient detail and clarity to permit internal and external review to validate encounter submissions and to assure Medically Appropriate services are provided consistent with the documented needs of the Member; and
  - (2)** Conforms to accepted professional practice; and
  - (3)** Is supported by written policies and procedures; and
  - (4)** Allows the Contractor to ensure that data received from Providers is accurate and complete by:
    - (a)** Verifying the accuracy and timeliness of reported data;
    - (b)** Screening the data for completeness, logic, and consistency; and
    - (c)** Collecting service information in standardized formats
- f.** Contractor shall ensure that the record keeping systems of its Participating Providers conform to the standards of this section.
- g.** Contractor shall review all internal policies and procedures on a biennial basis or as required by other sections in this Contract. Contractor shall submit timely, accurate and complete reports to OHA. OHA will post on its web site information about required reports, including the type of report, its location in Contract, the reporting due date, and where the report is to be submitted.
- h.** Contractor's failure to submit data, provide access to records or facilities, participate in consumer surveys or other accountability requirements in accordance with this Contract is noncompliance with the terms of this Contract and is grounds for sanction as specified in Exhibit B, Part 9.

- i. Contractor shall inform OHA if it has been accredited by a private independent accrediting entity. If the Contractor has been so accredited, Contractor shall authorize the private independent accrediting entity to provide OHA a copy of its most recent accreditation review, including:
  - (1) Accreditation status, survey type, and level (as applicable);
  - (2) Accreditation results, including recommended actions or improvements, corrective action plans, and summaries of findings; and
  - (3) Expiration date of the accreditation.

## 2. Privacy, Security and Retention of Records

- a. Maintenance and Security: Contractor shall ensure maintenance of a record keeping system that includes maintaining the security of records as required by the Health Insurance Portability and Accountability Act (HIPAA), 42 USC § 1320-d et seq., and the federal regulations implementing HIPAA, and complete Clinical Records that document the Covered Services received by the Member. Contractor shall have written policies and procedures establishing adherence to the aforementioned regulations and shall communicate these policies and procedures to its Subcontractors, regularly monitor its Subcontractors' compliance with these policies and procedures and take any Corrective Action necessary to ensure Subcontractor compliance. Contractor shall document all monitoring and Corrective Action activities. Such policies and procedures must ensure that records are secured, safeguarded and stored in accordance with applicable law including ORS 192.561, 413.171, and 414.679; OAR 410-141-3180; OAR 943-014-0300 through 943-014-0320; and OAR 943-120-0000 through 943-120-0200.
- b. Members must have access to the Member's 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 Participating Providers may charge the Member for reasonable duplication costs when the Member seeks copies of his or her records.
- c. Notwithstanding ORS 179.505, Contractor, its Provider Network and programs administered by OHA and DHS may 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 quality of care, lower the cost of care and improve the health and well-being of the Members.
- d. Contractor and its Provider Network may use and disclose sensitive diagnosis information including HIV and other health and mental health diagnoses, for the purpose of providing whole-person care. Individually identifiable health information must be treated as confidential and privileged information subject to ORS 192.553 to 192.581 and applicable federal privacy requirements. Redisclosure of individually identifiable information outside of the Contractor and the Provider Network for purposes unrelated to this section or the requirements of ORS 414.625, 414.632, 414.635, 414.638, 414.653 or 414.655 remains subject to any applicable federal or state privacy requirements.
- e. Contractor and its Provider Network may disclose information about Members to the OHA and DHS for the purpose of administering the laws of Oregon.

## 3. Access to Records

Contractor shall cooperate with, OHA, the Department of Justice Medicaid Fraud Control Unit (MFCU), and CMS, or other authorized state or federal reviewers, for the purposes of audits, inspection and

examination of Members' Clinical Records, whether those records are maintained electronically or in physical files.

Documentation must be sufficiently complete and accurate to permit evaluation and confirmation that Covered Services were authorized and provided, referrals made, and outcomes of coordinated care and referrals sufficient to meet professional standards applicable to the Health Care Professional and to meet the requirements for health oversight and outcome reporting in these rules.

Contractor shall retain, and shall require its Participating Providers to retain, Clinical Records for ten years after the Date of Services for which claims are made. If an audit, litigation, research and evaluation, or other action involving the records is started before the end of the ten-year period, Contractor shall retain, and shall cause its Participating Providers to retain, the Clinical Records until all issues arising out of the action are resolved.

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

#### **4. Payment Procedures**

- a.** Contractor shall pay for all Covered Services to Members and may require, except in the event of Emergency Services that Members obtain such Covered Services from Contractor or Providers affiliated with Contractor in accordance with OAR 410-141-3420 Billing and Payment.
- b.** Contractor shall ensure that neither OHA nor the Member receiving services are held liable for any costs or charges related to Contractor-authorized Covered Services rendered to a Member whether in an emergency or otherwise, including Holistic Care.
- c.** Except as specifically permitted by this Contract including TPR recovery, Contractor and its Subcontractors may not be compensated for Work performed under this Contract from any other 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 (NCCI).
- e.** Certain federal laws governing reimbursement of FQHCs, Rural Health Centers and Indian Health Care Providers may require OHA to provide supplemental payments to those entities, even though those entities have subcontracted with Contractor to provide Covered Services and including Indian Health Care Providers that do not have a subcontract with the Contractor. These supplemental payments are outside the scope of this Contract and do not violate the prohibition on dual payment contained herein. Contractor shall maintain encounter data records and such additional Subcontract information documenting Contractor's reimbursement to FQHCs, Rural Health Centers and Indian Health Care Providers, and to provide such information to OHA upon request. Contractor shall provide information documenting Contractor's reimbursement to non-participating Indian Health Care Providers to OHA upon request.
- f.** Contractor shall prohibit Subcontractors and Providers from billing Members, for Covered Services in any amount greater than would be owed if Contractor provided the services directly, consistent with 42 CFR § 438.106 and 42 CFR §438.230.
- g.** Contractor shall reimburse providers for all covered services delivered in integrated clinics by qualified providers.
- h.** Contractor shall support a warm handoff between levels or episodes of care for a member.

## 5. Claims Payment

- a. Claims that are subject to payment under this Contract by Contractor from 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 410-120-1340 and OAR 410-141-3420.
- b. Contractor may require Participating Providers to submit all billings for Members to Contractor within four months of the Date of Service, except under the following circumstances:
  - (1) Billing is delayed due to eligibility issues;
  - (2) Pregnancy of the Member;
  - (3) Medicare is the primary payer;
  - (4) Cases involving third party resources;
  - (5) Covered Services provided by Non-Participating Providers that are enrolled with OHA;  
or
  - (6) Other circumstances in which there are reasonable grounds for delay (which does not include a Subcontractor's failure to verify Member eligibility).
- c. Contractor shall have written procedures for processing claims submitted for payment from any source. The procedures shall specify time frames for and include:
  - (1) Date stamping claims when received;
  - (2) Determining within a specific number of days from receipt whether a claim is valid or non-valid;
  - (3) The specific number of days allowed for follow up of pended claims to obtain additional information;
  - (4) The specific number of days following receipt of additional information that a determination must be made;
  - (5) Sending notice of the decision with information on the member's Appeal rights to the Member when the determination is made to deny the claim;
  - (6) Making information on Appeal rights available upon request to a Member's authorized Member Representative who may be either a Participating Provider or a Non-participating Provider when the determination is made to deny a claim for payment; and
  - (7) The date of payment, which is the date of the check or date of other form of payment.
- d. Contractor shall pay or deny at least 90% of Valid Claims within 30 days of receipt and at least 99% of Valid Claims within 90 days of receipt. Contractors shall make an initial determination on 99% of all Valid Claims submitted within 60 days of receipt. The Date of Receipt of a Claim is the date the Contractor receives the claim, as indicated by its date stamp on the claim. Contractor and its Subcontractors may, by mutual agreement, establish an alternative payment schedule not to exceed the minimum requirements.
- e. Claims that are subject to payment under this Contract by Contractor from Non-Participating Providers who are enrolled with OHA will be billed to Contractor consistent with the requirements of OAR 410-120-1280 and 410-120-1300. If a Provider is not enrolled with OHA on the Date of Service, but the Provider becomes enrolled pursuant to OAR 410-120-1260(6)

“Provider Enrollment”, the claim shall be processed by Contractor as a claim from a Non-Participating Provider. Payment to Non-Participating Providers shall be consistent with the provisions of OAR 410-120-1340.

- f.** Contractor shall pay Indian Health Care Providers for Covered Services provided to those AI/AN enrolled with the Contractor who are eligible to receive services from such Providers, as follows:
- (1)** Participating Indian Health Care Providers are paid at a rate equal to the rate negotiated between the Contractor and the Participating Provider involved, which for a FQHC may not be less than the level and amount of payment which the Contractor would make for the services if the services were furnished by a Participating Provider which is not a FQHC.
  - (2)** Non-Participating Indian Health Care Providers that are not a FQHC must be paid at a rate that is not less than the level and amount of payment which the Contractor would make for the services if the services were furnished by a Participating Provider which is not an Indian Health Care Provider.
  - (3)** Non-Participating Indian Health Care Providers that are a FQHC must be paid at a rate equal to the amount of payment that the Contractor would pay a FQHC that is a Participating Provider with respect to the Contractor but is not an Indian Health Care Provider for such services.
- g.** Contractor shall make prompt payment to Indian Health Care Providers including Indian Tribe, Tribal Organization or Urban Indian Organization, in accordance with FFS timely payment, including paying of 90% of all Valid Claims from providers, within 30 days of the date of receipt; and paying 99 percent of all valid claims from providers within 90 days of the date of receipt per 42 §CFR 447.45 and 42 CFR §447.46.
- h.** In accordance with Section 5006 of the American Reinvestment and Recovery Act of 2009 (ARRA), Contractor shall not impose fees, premiums or similar charges on Indians served by an Indian health care provider, Indian Health Services (HIS); an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) or through referral under contract health services (CHS).
- i.** Contractor shall pay for Emergency Services that are received from Non-Participating Providers as specified in OAR 410-141-3140.

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

- (1)** Require all Providers to comply with the reporting requirements as a condition of payment from Contractor;
- (2)** Require all Providers to identify Provider-Preventable Conditions that are associated with claims for CCO Payment or with courses of treatment furnished to Members for which CCO Payment would otherwise be available; and
- (3)** Report all identified Provider-Preventable Conditions in a form or frequency as may be specified by OHA; and
- (4)** Not make payment to Providers for Provider-Preventable Conditions that are Health Care-Acquired Conditions or that meet the following criteria as specified in 42 CFR §447.26(b):
  - (a)** Is identified in the State plan.

- (b) Has been found by the State, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines.
- (c) Has a negative consequence for the Member.
- (d) Is auditable.
- (e) Includes, at a minimum, wrong surgical or other invasive procedure performed on a Member; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong Member.

## **6. Medicare Payers and Providers**

- a. For those Contractors affiliated with or contracted with an entity that provides services as a Medicare Advantage plan serving Fully Dual Eligibles, Contractor shall demonstrate on a yearly basis that its Provider Network is adequate to provide both the Medicare and the Medicaid Covered Services to its Fully Dual Eligible population. Contractor shall identify its Providers' Medicaid participation.
- b. Contractor shall coordinate care and benefits that are Covered Services with Medicare payers and Providers as Medically Appropriate for the purpose of achieving appropriate health outcomes for Members who are eligible for both Medicaid and Medicare.
- c. Contractor is responsible for Medicare deductibles, coinsurance and Co-Payments up to Medicare's or Contractor's allowable for Covered Services its Medicare eligible Members receive from a Medicare Provider (who is either a Participating Provider, or a Non-Participating Provider) if authorized by Contractor or Contractor's representatives, or for Emergency Services or Urgent Care Services.
- d. Contractor is not responsible for Medicare deductibles, coinsurance and co-payments for skilled nursing facility benefit days 21-100.
- e. Contractors that are affiliated with or contracted with an entity that provides services as a Medicare Advantage plan serving Fully Dual Eligible Members for Medicare and Medicaid may not impose cost-sharing requirements on Fully Dual Eligible Members and QMB that would exceed the amounts permitted by OHP if the Member is not enrolled in the Contractor's Medicare Advantage plan.
- f. Contractor shall report to the OHA Contract Administration Unit its affiliation or contract with Medicare Advantage Plan entities in Contractor's Service Area(s) using the Affiliated Medicare Advantage Plan Report which is available on the Contract Reports Web Site. Contractor shall update its Affiliated Medicare Advantage Report at any time there has been a Material Change in Contractor's operations that would affect adequate capacity and services, and annually no later than November 15, before the new Medicare plan year begins, and upon OHA request.

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

If Contractor is affiliated with or contracted with a Medicare Advantage plan for Fully Dual Eligibles for Medicare and Medicaid, Contractor shall verify current Member eligibility using the AVR system or the MMIS Web Portal.

- a. Pursuant to OAR 410-141-3120, Contractor shall coordinate with Medicare payers and Providers as Medically Appropriate to coordinate the care and benefits of Members who are eligible for both Medicaid and Medicare.

- b. Pursuant to OAR 410-141-3420(9), Contractor is responsible for Medicare deductibles, coinsurance and Co-Payments up to Medicare's or Contractor's allowable for Covered Services its Medicare eligible Members receive from a Medicare Provider, who is either a Participating Provider, or a Non-Participating Provider, if authorized by Contractor or Contractor's representatives, or for Emergency Services or Urgent Care Services.

## **8. All Payers All Claims (APAC) Reporting Program**

Contractor shall participate in the APAC reporting system established in ORS 442.464 and 442.466. Data submitted under this Contract may be used by OHA for purposes related to obligations under ORS 442.464 and 442.466 and OAR 409-025-0100 to OAR 409-025-0170. Submission of encounter data by OHA in accordance with this Contract will partially fulfill Contractor's responsibility for APAC submission. In addition to the submission of encounter data in accordance with this Contract, contractor submission of alternative payment methodology data to APAC will wholly fulfill Contractor's responsibility for APAC submission. Failure of Contractor to submit under this Contract the encounter data required to fulfill the responsibility for APAC reporting is subject to compliance and enforcement under OAR 409-025-0150 as well as under this Contract.

## **9. Administrative Performance Program**

- a. The Administrative Performance (AP) Standard utilizes the AP Penalty (APP) methodology described in this section. The APP methodology requires the submission of Valid Encounter Data, including pharmacy claims data that is submitted to OHA and certified in accordance with OAR 410-141-3430 and that is also submitted to the All Payer All Claims database by OHA or by Contractor. OHA may provide further instructions about the APP process. The APP process will not alter OHA's authority to administer the encounter data requirements of OAR 410-141-3430 or any other provisions under the Contract.
- b. For purposes of the APP methodology and calculations:
  - (1) All Valid Encounter Data, including Encounter Pharmacy Data, for a Subject Month must be submitted and accepted by OHA as meeting the AP Standard not later than the end of the Final Submission Month.
  - (2) OHA will send Contractor a Subject Month report within 30 days after the end of the Final Submission Month.
  - (3) If Contractor's Valid Encounter Data submissions for the Subject Month are complete and meet the AP Standard, OHA will issue a final Subject Month report and no withhold will occur.
  - (4) If Contractor's Valid Encounter Data submissions for the Subject Month have not met the AP Standard, OHA will provide a proposed Subject Month report. The proposed report will become final for purposes of the APP calculations 15 days after the date of the report, unless OHA receives from Contractor a written notice of appeal for the applicable Subject Month not later than 15 days after the date of the report. The notice of appeal from the Contractor must include written support for the appeal.
  - (5) Any appeal shall be conducted as an administrative review. The administrative review process will be conducted in the manner described in OAR 410-120-1580(4)-(6). Contractor understands and agrees that administrative review is the sole avenue for review of Subject Month reports for purposes of APP. The decision on administrative review shall result in a final Subject Month report if an appeal was timely filed.

- (6) OHA will rely upon the final report to determine whether the Contractor is subject to an AP Withhold for the Subject Month and the withhold amount.
- (7) If Contractor is subject to an AP Withhold pursuant to this section, after the conclusion of any appeal or the expiration of time to request an appeal, OHA will notify Contractor of the Withhold Month. In general, the AP Withhold for that Subject Month will be applied to the following calendar month's Capitation Payment.
- (8) OHA will place AP Withhold amounts not paid to Contractor into an AP pool. The AP pool consists of all AP Withhold amounts that are not distributed to any CCO, for a Subject Month, OHA will distribute the AP pool among CCOs that met the AP Standard for the Subject Month (eligible CCOs), allocated proportionately among eligible CCOs on the basis of Member Month Enrollment during the Subject Month. OHA will make AP pool distributions by separate payment to eligible CCOs after all AP appeals related to the Subject Month have been resolved.

## 10. Encounter Claims Data

- a. Contractor shall submit all Encounter Claims Data to OHA electronically using HIPAA Transactions and Codes Sets or the National Council for Prescription Drug Programs (NCPDP) Standards and Accredited Standardized Committee (ASC) X12N 834 and ASC X12N 835, formats as appropriate in accordance with OARs and OHA requirements.
- b. Contractor shall become a trading partner and conduct data transactions in accordance with OHA Electronic Data Transmission Rules; OAR 943-120-0100 through 943-120-0200.
- c. Contractor shall certify and attest that based on best information, knowledge, and belief, the data, documentation, and information submitted in its encounter claims is accurate, complete, and truthful in accordance with 42 CFR 438.604 and 438.606. Certification must be provided by the Contractor's Chief Executive Officer, Chief Financial Officer, or an individual who reports directly to the Chief Executive Officer or Chief Financial Officer with delegated authority to sign for the Chief Executive Officer or Chief Financial Officer. If the signing authority is delegated to another individual, the Chief Executive Officer or Chief Financial Officer retains final responsibility for the certification.
- d. Contractor shall demonstrate to OHA through proof of enrollment information, Encounter Data Certification and Encounter Data Validation that Contractor attests to the accuracy, completeness and truthfulness of information required by OHA. Contractor shall submit the following reports to OHA:

Encounter Data Certification and Validation Report, and  
Encounter Claim Count Verification Acknowledgement and Action Report  
Pharmacy Expense Proprietary Exemption Request Report  
Pharmacy Expense Report

The reports are available on the Contract Reports Web Site.

- e. Contractor shall maintain sufficient encounter data to identify the actual provider who delivers services to the Member per SSA section 1903(m)(2)(A)(xi).
- f. Contractor shall obtain a Coordination of Benefits Agreement (COBA) number and coordinate with COBA to receive direct crossover claims for dually eligible members with traditional Medicare per 42 CFR 438.3(t).

- g.** OHA will conduct periodic encounter data validation studies of the Contractor’s encounter submissions. These studies will review statistically valid random samples of encounter claims to establish a baseline error rate across Contractor’s provider network.
- h.** The purpose of encounter validation studies is to compare recorded utilization information from a medical record or other source with the Contractor’s submitted encounter data. Any and all covered services may be validated as part of these studies. The criteria used in encounter validation studies may include timeliness, correctness, sufficiency of documentation, and omission of encounters.
- i.** OHA will conduct encounter data validation studies to identify opportunities for technical assistance and establish a baseline error rate. Contractor shall take steps to improve the accuracy of its encounter data and improve upon the baseline error rate. For contract years 2+, Contractor’s failure to improve upon the baseline error rate may result in financial penalties or sanctions, and may require a corrective action plan for noncompliance with related encounter submission requirements.
- j.** Encounter data validation studies may include claims data used to calculate quality metrics or incentive pool metrics.

**11. Encounter Data Submission and Processing**

- a.** Contractor shall submit Valid Encounter Data at least once per calendar month, including Encounter Pharmacy Data, in accordance with the AP Standard not later than the last day of the Final Submission Month.
- b.** Contractor shall submit valid Encounter Data on forms or formats specified by OHA and in accordance with OAR 410-141-3430 and OAR 943-120-0100 through 943-120-0200.
- c.** The Encounter Data submitted must represent no less than 50 percent of all Encounter claim types received and adjudicated by Contractor during that calendar month, including the paid amounts regardless of whether the Provider is paid on a fee-for-service or capitated basis, or whether the Provider is in network (participating) or out of network (non-participating).
- d.** Contractor shall correct errors in Encounter Data if the Encounter Data cannot be processed because of missing or erroneous information. Corrective Action will be initiated if more than 5% of any Encounter Data submission cannot be processed because of missing or erroneous information.
- e.** For purposes of this section, the AP Standard allows for Contractor delay of no more than 5% of non-pharmacy encounter claims for the Subject Month with prior notification to OHA. Contractor may submit documentation to OHA citing specific circumstances that will result in a delay to Contractor’s timely submittal of Valid Encounter Data.
- f.** If Contractor submits documentation of a delay in encounter claims submission, OHA will review the documentation and make a determination within 30 days on whether the circumstances cited are Acceptable and that a Corrective Action Plan is not necessary to remedy the deficiency.
- g.** These “Acceptable” circumstances may include, but are not limited to:
  - (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; or
- (6) OHA recognized system issues preventing timely submission of Encounter Data including systems issues preventing timely submission to the All Payer All Claims database.

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

## **12. Encounter Claims Data (Non-Pharmacy)**

- a. Contractor shall submit all valid unduplicated Non-Pharmacy Encounter Data to OHA within 45 days of the Claims Adjudication date. The Claims Adjudication date is the date of Contractor’s payment or denial. Corrective Action will be initiated if the Encounter Data submitted are over 45 days after the Claims Adjudication date or if the submissions of duplicate claims exceed 5% per month.
- b. Contractor shall correct errors in Encounter Data if the Encounter Data cannot be processed because of missing or erroneous information. Corrective Action will be initiated if more than 5% of any Encounter Data submission cannot be processed because of missing or erroneous information.
- c. Contractor shall submit all Encounter Data including the allowed amount and paid amount as required by 42 CFR 438.818, if allowed through state transaction/submission process.
- d. OHA will notify Contractor of the status of all Encounter Data processed. Notification of all Encounter Data that must be corrected will be provided to Contractor each week. Encounter Data on this notification is referred to as “Encounter Data Requiring Correction.” OHA will not necessarily notify Contractor of report errors.
- e. Contractor shall submit corrections to all Encounter Data Requiring Correction within 63 days of the date OHA sends Contractor notice. Encounter Data Requiring Correction that are not corrected to be Valid Encounter Data within 63 days of OHA notification are subject to Corrective Action.

## **13. Encounter Pharmacy Data**

- a. The Encounter Pharmacy Data submitted must represent no less than 50 percent of all pharmacy claim types received and adjudicated by Contractor during that calendar month, including the paid amounts regardless of whether the Provider is paid on a fee-for-service or capitated basis, or whether the Provider is in network (participating) or out of network (non-participating).
- b. Contractor shall submit all valid, accepted liability, unduplicated Encounter Pharmacy Data to OHA within 45 days of the dispense date. Corrective action will be initiated if the Encounter Pharmacy Data submitted are over 45 days after the dispense date or if the submission of duplicate claims exceed 5% per month.
- c. Contractor shall correct errors in Encounter Pharmacy Data if the Encounter Pharmacy Data cannot be processed because of missing or erroneous information. Corrective Action will be initiated if more than 5% of any pharmacy data submission cannot be processed because of missing or erroneous information.

- d. OHA will notify Contractor of the status of all Encounter Pharmacy Data processed. Notification of all Encounter Pharmacy Data that must be corrected will be provided to Contractor each week. Encounter Pharmacy Data on this notification is referred to as “Pharmacy Data Requiring Correction.” OHA will not necessarily notify Contractor of report errors.

#### **14. Drug Rebate Program**

- a. Contractor acknowledges that OHA is eligible for the rebates authorized under Section 1927 of the Social Security Act (42 USC 1396r-8), as amended by section 2501 of the Patient Protection and Affordable Care Act (P.L. 111-148), section 1903(m)(2)(A)(xiii) and section 1206 of the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152).
- b. Covered outpatient drugs dispensed to Members are subject to the same rebate requirements under section 1927, and OHA will retain all funds collected from such rebates from manufacturers, unless the drug is subject to discounts under Section 340B of the Public Health Service Act.
- c. Contractor shall report any rebates it receives directly or that its contracted PBM receives from a manufacturer to OHA.
- d. Contractor shall provide and require its subcontractors to provide sufficient data and information for OHA to secure federal drug rebates for all utilization and administration of any covered outpatient drug provided to Members.
- e. Such utilization information must include, at a minimum;
  - (1) Information on the total number of units of each dosage form and strength and package size by National Drug Code of each covered outpatient drug dispensed to Members;
  - (2) The date of service (date of dispense) and actual claim paid date;
- f. Contractor shall submit this NDC level information on drugs, biologics, and other Provider-administered products, including, but not limited to drug codes, units and conversions consistent with federal and Department requirements.
- g. Contractor shall report prescription drug data within 45 days of the quarter in which the service was rendered, pursuant to 42 CFR 438. Contractor shall report to the OHA, on a timely and periodic basis specified by the Secretary, information on the total number of units of each dosage form and strength and package size by National Drug Code of each covered outpatient drug dispensed to Members and other data as the Secretary determines necessary, including the National Drug Code of each covered outpatient drug dispensed to Members.

#### **15. Encounter Data Submissions Dispute Resolution**

- a. When OHA, receives an Invoiced Rebate Dispute from a drug manufacturer, OHA will send the Invoiced Rebate Dispute to the Contractor for review and resolution. The Contractor shall assist in the resolution process as follows:
- b. Notify OHA’s Encounter Data Liaison, within 15 days of receipt of an Invoiced Rebate Dispute if Contractor agrees or disagrees;
- c. If the Contractor agrees with the Invoiced Rebate Dispute that an error has been made, Contractor shall correct and re-submit the Encounter Data to OHA, within 45 days of receipt of the Invoiced Rebate Dispute; or

If Contractor disagrees with the Invoiced Rebate Dispute that an error has been made, Contractor shall send the details of the disagreement to OHA’s Encounter Data Liaison, within 45 days of receipt of the Invoiced Rebate Dispute.

**16. Third Party Liability and Personal Injury Liens**

- a.** If a Member has other insurance coverage available for payment of Covered Services, such resources are primary to the coverage provided by the Contractor under this Contract and must be exhausted prior to payment for such Covered Services by Contractor. Member cost-sharing incurred as part of such other coverage shall be paid to such insurer by Contractor.
- b.** “Third Party Liability” mean any individual, entity, or program that is, or may be, liable to pay all or part of the medical cost of any medical assistance furnished to a Member. Contractor shall retain those recoveries and report to OHA per (11)(f) of this section. Contractor shall take all reasonable actions to pursue recovery of Third Party Liability for Covered Services provided during the Contract period and up to 24 months from the claim paid date.
- c.** OHA and its subcontractor(s) shall take all reasonable actions to pursue recovery of Third Party Liability for Covered Services not recovered by Contractor, beyond 24 months. Any recoveries by OHA will be reported and utilized in the Rate Development process.
- d.** Contractor shall develop and implement written policies describing its procedures for Third Party Liability recovery.
- e.** Policies at a minimum must describe:
  - (1)** The requirement for providers to request Third Party Liability information from the members
  - (2)** The requirement to report to OHA within the specified timeframe when TPL is identified
  - (3)** The requirement to pursue recovery for Covered Services, and
  - (4)** The requirement to adjust encounter claims to reflect the amount received or recovered from the primary payer.
- f.** OHA will review Contractor’s policies and procedures for compliance with this Contract and, to the extent OHA determines applicable, for consistency with Third Party Liability recovery requirements in 42 USC 1396a(a)(25), 42 CFR 433 Subpart D, OAR 461-195-0301 to 461-195-0350, OAR 410-141-3080 and ORS 416.510 to 416.610.
- g.** Contractor shall submit the policy as follows:
  - (1)** To the OHA Contract Administration Unit annually no later than January 31<sup>st</sup> or attest to no change using Attestation form on CCO forms page;
  - (2)** To OHA Contract Administration Unit upon any significant changes, prior to formal adoption of the policy. OHA will notify Contractor within 30 days of the compliance status of the policy;
  - (3)** To the OHA Contract Administration Unit anytime upon OHA request. OHA will notify Contractor within 30 days of the compliance status of the policy; and
  - (4)** Subject to OHA prior approval, Contractor shall furnish such information to:
    - (a)** Potential Members before and during Enrollment; and
    - (b)** Members within 90 days after adopting the policy with respect to any particular service.

- h.** If Contractor or its subcontractors or affiliated entities have other lines of business related to third party insurance coverage such as Medicare Advantage or other individual or employer-sponsored plans, Contractor shall arrange to compare its monthly enrollment records to ensure that all Third Party Liability is identified and promptly report any matches to OHA within the timeframes specified in this section.
- i.** If Contractor receives information that a member has coverage outside of OHP by a third party insurer, Contractor agrees to notify OHA within 30 days and supply all requested coverage information via the online TPL reporting portal or by other format as prescribed by OHA, and require that its providers and subcontractors report to OHA when they become aware a member has other coverage.
- j.** Failure to report TPL to OHA within the specified timeframe will result in a financial penalty equal to the monthly capitation amount received by Contractor for that member for each month the member was also enrolled in third party coverage.
- k.** Contractor shall maintain records of Contractor’s actions and Subcontractors’ actions related to Third Party Liability recovery and make those records available for OHA review. Contractor shall document and retain, at the claim level, details related to recoveries from Third Party Liability to allow reconciliation and audit of reported recoveries and adjusted encounter claims data.
- l.** Contractor shall report all Third Party Recoveries on the OHP Coordination of Benefits and Subrogation Recovery Section on the Quarterly Report, Report L.6 of Exhibit L.
- m.** Contractor retains all responsibility to adjust any encounter claims within the timeframe specified for encounter data adjustments to reflect Third Party Recoveries for those claims.
- n.** Contractor shall maintain records of Third Party Liability recovery actions that do not result in recovery, including Contractor’s written policy establishing the threshold for determining that it is not Cost Effective to pursue recovery action.
- o.** Contractor will receive from OHA all Third Party Liability and eligibility information available to OHA, in order to assist in the pursuit of financial recovery, as it pertains to Third Party Liability and Personal Injury Liens.
- p.** Contractor agrees to provide and require its subcontractors or affiliated entities to provide to OHA all Third Party Liability and eligibility information in order to assist in the pursuit of financial recovery. Contractor agrees to respond and require its subcontractors to respond in a timely manner to requests for information.

**17. Personal Injury Lien**

- a.** Contractor and its subcontractors must provide notification of all potentially liable third parties within 14 days to the Personal Injury Lien Unit of OHA’s Office of Payment and Recovery’s (OPAR), consistent with OAR 461-195-0301 to 461-195-0350.
- b.** Contractor must receive a written lien assignment from OHA or designee prior to any attempt to seek reimbursement from the recipient’s proceeds arising from an injury or death caused by a third party, and must notify OHA within 14 days once a lien has been filed. Contractor agrees to provide to OHA or designee a list of all active PIL cases upon request.
- c.** Contractor must submit a copy of its lien release for review and approval to OHA by 31 January of each year, and at any time there is a material change to the document. The lien resolution must clearly state that Contractor has the authority to resolve liens assigned to them and does not have the authority to act on behalf of the state beyond the assigned lien.

- d.** Contractor must notify the Personal Injury Lien Unit of the resolution of any liens within 30 days, and include the following information:

  - (1)** The amount of lien asserted
  - (2)** The amount received for the release of the lien.
  - (3)** The settlement amount received by enrollee.
- e.** Contractor may not refuse to provide Covered Services and shall require that its Participating Provider may not refuse to provide Covered Services, to a Member because of a Third Party potential liability for payment for the Covered Service.
- f.** If a claim advances to litigation that has been previously assigned to Contractor, Contractor will provide notification to OHA within 10 days of initiating the action and include the information specified in OAR 461-195-0310. Contractor agrees to promptly reassign the lien to OHA upon request.
- g.** Contractor is the payer of last resort when there is other insurance or Medicare in effect. At OHA’s discretion or at the request of the Contractor, OHA may retroactively disenroll a Member to the time the Member acquired Third Party Liability insurance, pursuant to OAR 410-141-3080(3)(e)(B) or 410-141-3080(9)(a) based on OHA’s determination that services may be provided Cost Effectively on a fee-for-service basis. When a Member is retroactively disenrolled under this section of this Contract, OHA will recoup all CCO Payments to Contractor for the Member after the effective date of the Disenrollment. Contractor and its Providers may not seek to collect from a Member (or any financially responsible Member Representative) or any Third Party Liability, any amounts paid for any Covered Services provided on or after the date of Disenrollment.
- h.** Contractor shall comply with 42 USC 1395(b), 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.
- i.** Where Medicare and Contractor have paid for services, and the amount available from the Third Party Liability is not sufficient to satisfy the claims of both programs to reimbursement, the Third Party Liability must reimburse Medicare the full amount of its claim before any other entity, including Contractor or its Subcontractors, may be paid.
- j.** If the Third Party has reimbursed Contractor or its Participating Providers or Subcontractors, or if a Member, after receiving payment from the Third Party Liability, has reimbursed Contractor or its Subcontractors or Participating Providers, the Contractor or its Subcontractors or Participating Providers must reimburse Medicare up to the full amount the Contractor or Subcontractors or Participating Providers received, if Medicare is unable to recover its payment from the remainder of the Third Party Liability payment.
- k.** Any such Medicare reimbursements described in this section are the Contractor’s responsibility on presentation of appropriate request and supporting documentation from the Medicare carrier. Contractor shall document such Medicare reimbursements in its report to OHA.
- l.** When engaging in Third Party Liability recovery actions, Contractor shall comply with, and require its Subcontractors or agents to comply with, federal and State confidentiality requirements, described in Exhibit E of this Contract. Contractor agrees to comply and require its Subcontractors to comply with ORS 416.510 through 416.610 when enforcing an assigned lien. OHA considers the disclosure of Member claims information in connection with Contractor’s

TPR recovery actions a purpose that is directly connected with the administration of the Medicaid program.

## **18. Disclosure of Ownership Interest**

- a.** Contractor shall provide disclosures in accordance with 42 CFR §455.100 through 42 CFR §455.106 and, in particular 42 CFR §455.104(b), shall provide information regarding each person or corporation with an ownership or control interest (which equals or exceeds 5 percent) in the Coordinated Care Organization, or any Subcontractor in which Contractor has an ownership interest that equals or exceeds 5 percent, consistent with 42 CFR §455.104 to 455.106. Disclosures will be reviewed by OHA in accordance with 42 CFR §438.602(c) and 438.608(c). Such disclosures shall include the following:
- (1) Whether any of the persons named in this Section 13 are related to one another as a spouse, parent, child or sibling. In accordance with 42 CFR §455.104(b) disclosures that shall be provided to OHA include the following:
    - (a) Name and address (the address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.)
    - (b) Date of birth and Social Security Number (in the case of an individual).
    - (c) Other tax identification number (in the case of a corporation)
    - (d) The name of any other Medicaid provider or fiscal agent in which the person or corporation has an ownership or control interest.
    - (e) The name, address, date of birth, and Social Security Number of any managing employee of the Contractor
  - (2) Name any other disclosing entity in which a person named in this Section 14 also has an ownership or controlling interest.
  - (3) Any person with an ownership or control interest in a Subcontractor with whom the Contractor has had business transactions totaling more than \$25,000 during a 12 month period ending on the date of request; and any significant business transactions between Contractor and a wholly-owned supplier or between Contractor and a Subcontractor during a 5 year period ending on the date of request.
  - (4) Any person who has an ownership or controlling interest in the Contractor, or is an agent or managing employee of the Contractor, and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or other federal services program since inception of those programs.
- b.** Any person who has an ownership or controlling interest in the Contractor, or is an agent or managing employee of the Contractor shall submit to the OHA Contract Administration Unit the appropriate disclosures at the following times:
- (1) Within at least 90 days prior to any changes in ownership or controlling interest of 5 percent or more;
  - (2) Upon request of OHA during re-evaluation of Enrollment processes under 42 CFR §455.414;
  - (3) Within 35 days after any change in ownership, with equity shares transferred being less than 50%;
  - (4) When Contractor executes a contract with OHA; and

- (5) When Contractor amends the contract with OHA through renewal or extension.

**19. Upon renewal or extension of the Contract**

Change in ownership is consolidation or merger of Contractor, or of a corporation or other entity or person controlling or controlled by Contractor, with or into a corporation or entity or person, or any other reorganization or transaction or series of related transactions involving the transfer of more than 50% of the equity interest in Contractor or more than 50% of the equity interest in a corporation or other entity or person controlling or controlled by Contractor, or the sale, conveyance or disposition of all or substantially all of the assets of Contractor, or of a corporation or other entity or person controlling or controlled by Contractor, in a transaction or series of related transactions as specified in 42 CFR §455.104(c)(3).

- a. Contractor shall notify OHA at least 90 days prior to any change in ownership and reimburse OHA for all legal fees reasonably incurred by OHA in reviewing the proposed assignment or transfer and in negotiating and drafting appropriate documents.
- b. Contractor shall notify OHA of any changes of address, and as applicable licensure status as a health plan with DCBS or as a Medicare Advantage plan, or Federal Tax Identification Number (TIN), within 14 days of the change.
- c. Failure to notify OHA of any of the above 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 the Contractor set forth in this Contract and in the Application for this Contract. Contractor may not transfer, Subcontract, reassign or sell its contractual or ownership interests, such that Contractor is no longer available to provide OHA with its expertise, experience, judgment and representations and certifications, without first obtaining OHA's prior written approval 120 days before such transfer, subcontract, reassignment or sale occurs, except as otherwise provided in Exhibit B, Part 4, Section 11 of this Contract governing adjustments in Service Area or Enrollment and Exhibit D, Section 18 "Subcontracts".
- e. As a condition precedent to obtaining OHA's approval, Contractor shall provide to OHA Contract Administration Unit all of the following:
  - (1) The name(s) and address(es) of all directors, officers, partners, owners, or persons or entities with beneficial ownership interest of 5% or more of the proposed new Entity's equity;
  - (2) Representation and warranty signed and dated by the proposed new Entity and by Contractor that represents and warrants that the policies, procedures and processes issued by the current Contractor will be those policies, procedures, or processes provided to OHA by the current Contractor or by an existing Contractor within the past two years, and that those policies, procedures and processes still accurately describe those used at the time of the ownership change and will continue to be used once OHA has approved the ownership change request, except as modified by ongoing Contract and Administrative Rule requirements. If Contractor and the proposed new Entity cannot provide representations and warranties required under this subsection, OHA shall be provided with the new policies, procedures and processes proposed by the proposed new Entity for review consistent with the requirements of this Contract;

- (3) The financial responsibility and solvency information for the proposed new Entity for OHA review consistent with the requirements of this Contract;
  - (4) Contractor’s assignment and assumption agreement or such other form of agreement, assigning, transferring, subcontracting or selling its rights and responsibilities under this Contract to the proposed new Entity, including responsibility for all records and reporting, provision of services to Members, payment of Valid Claims incurred for dates of services in which Contractor has received a CCO Payment, and such other tasks associated with termination of Contractor’s contractual obligations under this Contract.
- f. OHA may require Contractor to provide such additional information or take such actions as may reasonably be required to assure full compliance with Contract terms as a condition precedent to OHA’s agreement to accept the assignment and assumption 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.

**20. Subrogation**

Contractor agrees, and shall require its Subcontractors to agree, to subrogate to OHA any and all claims the Contractor or Subcontractor has or may have against manufacturers, wholesale or retail suppliers, sales representatives, testing laboratories, or other Providers in the design, manufacture, Marketing, pricing, or quality of drugs, pharmaceuticals, medical supplies, medical devices, DMEPOS, or other products. Nothing in this provision prevents Oregon from working with the Contractor and releasing its right to subrogation in a particular case.

**21. Contractor’s Board of Directors**

Contractor shall promptly notify OHA of any change in membership in Contractor’s board of directors. Such notice shall be provided within 30 days of any such change.

## **Exhibit B –Statement of Work - Part 9 – Program Integrity**

### **1. Monitoring and Compliance Review**

- a.** OHA is responsible for monitoring compliance with the requirements in this Contract. Methods of monitoring compliance may include review of documentation submitted by Contractor, Contract performance review, review of Grievances, reports generated by the EQRO, on-site review of documentation or any other source of relevant information, including Contractor and Subcontractor information and cooperation required under Exhibit B, Part 8. Contractor agrees to cooperate and require its Subcontractors to cooperate to make any and all records and facilities available for compliance review.
- b.** If compliance cannot be determined, or if OHA determines that Contractor is non-compliant with the requirements of the Contract, OHA may find Contractor has breached Contract requirements and may impose Liquidated Damages, financial penalties or Sanctions and pursue any other remedies available under this Contract.
- 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 the Contractor’s ability to meet the access, performance and quality goals of the Contract, or any negative impacts to Member access, quality of care or Member rights.
- d.** Upon identification of performance issues, deficiencies, indications that quality, access or cost containment goals are being compromised, or that circumstances exist that affect Member rights or health, OHA will promptly intervene within 30 days of identifying a concern to remediate the identified issue(s) and require Contractor to develop and implement a Corrective Action Plan (CAP).
- e.** If Contractor fails to remedy the deficiencies, or fails to improve performance within the specified timeframe, the state may require Contractor to develop and implement a Corrective Action Plan. OHA must inform CMS if Contractor is placed on a Corrective Action Plan or is at risk of Sanction, and report on the effectiveness of its remediation efforts.

### **2. Conditions that may Result in Sanctions**

- a.** OHA may impose Sanctions if it determines that Contractor has acted or failed to act as described in this Section or any other provision of this Contract. OHA’s determination may be based on findings from an onsite survey, Member or other complaints, financial status or any other source.
- b.** Conditions that may result in a Sanction under this section may include when Contractor acts or fails to act as follows:
  - (1)** Fails substantially to provide Medically Appropriate services that the Contractor is required to provide, under law or under its Contract with OHA, to a Member covered under this Contract;
  - (2)** Imposes on Members premiums or charges that are in excess of the premiums or charges permitted under the Medical Assistance Program;
  - (3)** Acts to discriminate among Members on the basis of their protected class such as race, ethnicity, national origin, religion, sex, sexual orientation, marital status, age, or disability, their health status or their need for health care services. This includes, but is not limited to, termination of Enrollment or refusal to reenroll a Member, except as permitted under this Contract, any practice that would reasonably be expected to discourage Enrollment or seek the disenrollment of individuals whose protected class,

- medical condition or history indicates probable need for substantial future medical services;
- (4) Misrepresents or falsifies any information that it furnishes to CMS or to the State, or its designees, including but not limited to the assurances submitted with its application or Enrollment, any certification, any report required to be submitted under this Contract, encounter data or other information relating to care or services provided to a Member;
  - (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 set forth in 42 CFR §422.208 and 422.210, and this Contract;
  - (7) Fails to comply with the operational and financial reporting requirements specified in this Contract;
  - (8) Fails to maintain a Participating Provider Panel sufficient to ensure adequate capacity to provide Covered Services under this Contract;
  - (9) Fails to maintain an internal Quality Improvement program, or Fraud, Waste and Abuse prevention program, or to provide timely reports and data required under this Contract;
  - (10) Fails to maintain an internal QA/PI program;
  - (11) Fails to comply with Grievance and Appeal requirements, including required notices, continuation or reinstatement of benefits, expedited procedures, compliance with requirements for processing and disposition of Grievances and Appeals, and record keeping and reporting requirements;
  - (12) Fails to pay for Emergency Services and post-emergency stabilization services or Urgent Care Services required under this Contract;
  - (13) Fails to follow accounting principles or accounting standards or cost principles required by federal or State laws, rule or regulation, or this Contract;
  - (14) Fails to make timely claims payment to Providers or fails to provide timely approval of authorization requests;
  - (15) Fails to disclose required ownership information or fails to supply requested information to OHA on Subcontractors and suppliers of goods and services;
  - (16) Fails to submit accurate, complete, and truthful encounter data in the time and manner required by Exhibit B, Part 8, Section 7;
  - (17) Fails to submit accurate, complete and truthful Pharmacy Data in the time and manner required by Exhibit B, Part 8, Section 9; or
  - (18) 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;
  - (19) Fails to comply with a term or condition of this Contract, whether by default or breach of this Contract. Imposition of a sanction for default or breach of this Contract does not limit OHA's other available remedies;
  - (20) 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;

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

### 3. Range of Sanctions Available

- a. The use of one sanction by OHA does not preclude the imposition of any other sanction or combination of Sanctions or any other remedy authorized under this Contract for the same deficiencies. OHA may impose a sanction while requiring the development and implementation of a Corrective Action Plan if the deficiencies are severe or numerous.
- b. OHA may assess financial penalties in the amounts authorized in 42 CFR 438.704. If OHA imposes financial penalties as provided under 42 CFR 438.702(a)(1), the maximum penalty varies depending on the nature of the infraction.
- c. The limit is \$25,000 for each determination where OHA finds Contractor has:
  - (1) Failed substantially to provide Medically Appropriate services that the Contractor is required to provide, under law or under its Contract with OHA, to a Member covered under this Contract;
  - (2) Misrepresented or falsified any information that it furnished to CMS or to the State, or its designees, including but not limited to the assurances submitted with its application or Enrollment, any certification, any report required to be submitted under this Contract, encounter data or other information relating to care or services provided to a Member;
  - (3) Failed to comply with the requirements for Physician Incentive Plans, as set forth in 42 CFR §422.208 and 422.210, and this Contract; or
  - (4) Distributed directly or indirectly through any agent or independent contractor, Marketing materials that have not been approved by the State or that contain false or materially misleading information.
- d. The limit is \$100,000 for each determination where OHA finds Contractor has:
  - (1) Acted to discriminate among Members on the basis of their protected class such as race, ethnicity, national origin, religion, sex, sexual orientation, marital status, age, or disability, their health status or their need for health care services. This includes, but is not limited to, termination of Enrollment for a Member, except as permitted under this Contract, or any practice that would reasonably be expected to discourage Enrollment by individuals whose protected class, medical condition or history indicates probable need for substantial future medical services; or
  - (2) Misrepresented or falsified any information that it furnished to CMS or to the State.
- e. The limit is \$15,000 for each Member OHA determines was not enrolled on the basis of their health status or their need for health care services.
- f. In addition to the specific penalties identified in Section 3, OHA may:
  - (1) Assess a Recovery Amount equal to one percent (1%) of Contractor's last monthly CCO Payment immediately prior to imposition of the sanction, to be deducted from Contractor's next monthly CCO Payment after imposition of the sanction;
  - (2) Grant Members the right to disenroll without cause (OHA may notify the affected Members of their right to disenroll);

- (3) Suspend all new Enrollment, including Enrollment from auto assignment, or transfer any of Contractor's enrolled Members after the effective date of the sanction;
  - (4) Suspend payment for Members enrolled after the effective date of the sanction until OHA is satisfied that the reasons for imposition of the sanction no longer exists and is not likely to recur;
  - (5) Deny payments under this Contract for new Members when, and for so long as, payment for those members is denied by CMS in accordance with 42 CFR §438.730;
  - (6) Require Contractor to develop and implement a Corrective Action Plan that is acceptable to OHA for correcting the problem;
  - (7) Where financial solvency is involved, actions may include increased reinsurance requirements, increased reserve requirements, market conduct constraints, or financial examinations; and
  - (8) Impose any other Sanctions, in accordance with 42 CFR §438.702, reasonably designed to remedy or compel future compliance with this Contract.
- g.** If OHA determines that there is continued egregious behavior or that there is substantial risk to Members' welfare, or that action is necessary to ensure the health of Members while improvements are made to remedy violations or until there is an orderly termination or reorganization by Contractor:
- (1) OHA must require Contractor to implement temporary management mechanisms, such as employment of consultants or other individuals or entities approved by OHA at Contractor's expense;
  - (2) OHA must grant Members the right to disenroll without cause and notify Members of the right to disenroll without cause;
  - (3) OHA must not delay the imposition of temporary management mechanisms to provide for Administrative Review before imposing this sanction; and
  - (4) OHA must not terminate temporary management mechanisms until it determines that Contractor can ensure that the sanctioned behavior will not recur.

#### **4. Corrective Action Plan**

- a.** If OHA requires Contractor to develop and implement a Corrective Action Plan, the Corrective Action Plan must include, at a minimum:
- (1) A description of the issues and factors which contributed to the deficiency;
  - (2) Designation of a person within Contractor's organization charged with the responsibility of correcting the issue;
  - (3) A detailed description of the specific actions Contractor will take to remedy the deficiency;
  - (4) A timeline for when those actions will begin and when the deficiency will be corrected;
  - (5) Identification of any member access to care issues that were caused as a result of the deficiency;
  - (6) If the deficiency originated with a Subcontractor, a description of how Contractor intends to monitor Subcontractor performance to prevent reoccurrence;

(7) A timeframe no less than 180 days from the projected correction date when Contractor shall provide a status update to OHA to demonstrate that the actions taken to remedy the deficiency have effectively corrected the issue.

b. If Contractor fails to submit a Corrective Action Plan that is acceptable to OHA within the specified time period or does not implement or complete the Corrective Action within the specified time period, OHA will proceed with other Sanctions or with termination of this Contract.

## 5. Liquidated Damages

a. Contractor acknowledges that any failure to meet the responsibilities or specific performance standards for deliverables to OHA outlined in the Contract results in damages to OHA in the form of additional work on the part of OHA staff, failure to meet internal deadlines, or unanticipated project delays.

b. The liquidated damages prescribed in this section are intended to be reasonable estimates of projected financial loss and damage resulting from the Contractor's nonperformance of specific contract requirements. In the event of Contractor's failure to perform in accordance with this Contract, OHA may assess liquidated damages as provided in this section.

c. If the Contractor fails to perform any of the services described in the Contract, OHA may assess liquidated damages for each occurrence listed in the table below. Any liquidated damages assessed by OHA shall be due and payable within thirty (30) days after Contractor receives notice of the assessed damages, regardless of any dispute in the amount or interpretation which led to the notice.

d. The decision to assess liquidated damages does not prohibit OHA from imposing any other financial penalty or Sanction.

e. If liquidated damages are assessed, OHA may elect to collect:

(1) Through direct assessment and request for payment delivered to the Contractor; or

(2) By deduction of amounts assessed as liquidated damages from, and as set-off against payments due to the Contractor or that become due at any time after assessment of the liquidated damages. OHA will make deductions until it has collected the full amount payable by the Contractor.

f. Contractor will not pass through liquidated damages imposed under this Contract to a Provider or Subcontractor, unless the Provider or Subcontractor caused the damage through its own action or inaction. Nothing described herein shall prohibit a Provider or a Subcontractor from seeking judgment before an appropriate court in situations where it is unclear that the Provider or the Subcontractor caused the damage by an action or inaction.

g. All liquidated damages imposed pursuant to this Contract, whether paid or due, shall be paid by the Contractor out of administrative costs and profits.

**h. Liquidated Damages Issues and Amounts**

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

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

**6. Intermediate Sanctions**

**a. Civil Monetary Penalties**

- (1)** Contractor acknowledges that any failure to meet the responsibilities or specific performance standards for access and service delivery outlined in the Contract negatively impacts Members and the overall goals of Health System Transformation.

(2) The civil monetary penalties outlined in this section are intended to penalize an act or the failure to act in a manner which could result in harm to a member or otherwise inhibit timely and appropriate access to care.

(3) Financial Penalty Issues and Amounts

Failure to terminate a provider who becomes ineligible to participate in Medicaid	\$500 per occurrence in addition to \$250 per day until the provider is terminated
Failure to provide a timely and content-compliant Notice of Adverse Benefit Determination to a member within the timeframe defined in Contract and OAR	\$1,000 per occurrence
Delegation of an Appeal to a subcontractor or delegated entity in violation of Contract terms	\$1,000 per occurrence
Failure to provide a timely response to a Provider’s request for Prior Authorization within the timeframes defined in OAR 410-141-3225	\$250 per occurrence
Failure to enroll a Member on the basis of their health status or their need for health care services.	\$15,000 per member not to exceed \$100,000 per determination

(4) Nothing in this section prohibits OHA from issuing financial penalties outside of the specific infractions identified in (3) for any instance of Contractor’s failure to perform or meet requirements of this Contract.

(5) If OHA elects to issue a financial penalty for an infraction that is not listed in (3) above, the specific amount of the penalty is at OHA’s discretion.

**7. Sanction Process**

- a. OHA will notify the Contractor in writing of its intent to impose a sanction. The notification shall explain the factual basis for the sanction, reference to the section(s) of this Contract or federal or State law or regulation that has been violated, explain the actions expected of Contractor, and state the Contractor’s right to file a request for Administrative Review with the Director of OHA in writing within 30 days of the date of the sanction notice.
- b. In cases in which OHA determines that conditions could compromise a Member’s health or safety, OHA may provisionally impose the sanction before such Administrative Review opportunity is provided.
- c. Contractor shall make payments in full to OHA within 30 days of the date of the sanction notice, unless Contractor has made a timely request for Administrative Review in which case Contractor may withhold payment of a disputed amount pending the issuance of the Administrative Review decision. Absent a timely request for Administrative Review, if Contractor fails to make payment within 30 days of the sanction notice, OHA will recoup the recovery payment from Contractor’s future CCO Payment(s) or as otherwise provided under this Contract, until the payment is satisfied.

- d. The Administrative Review process will be conducted in the manner described in OAR 410-120-1580(4)-(6). Contractor understands and agrees that Administrative Review is the sole avenue for review of sanction decisions under this Contract.
- e. If the State imposes a civil monetary penalty on the Contractor for charging premiums or charges in excess of the amounts permitted under Medicaid (i.e., excessive copays, etc.), the State will deduct the amount of the overcharge from the penalty and return the excess to the Member.

## 8. Notice to CMS of Contractor Sanction

OHA will provide written notice to the CMS Regional Office no later than 30 days after OHA has imposed a sanction on Contractor in accordance with 42 CFR 438.724. OHA may choose to provide written notice to the CMS Regional Office whenever Contractor has a civil monetary penalty imposed by OHA for any breach or violation of this Contract.

## 9. Compliance Plan

- a. Contractor shall develop and implement a Compliance Plan in accordance with requirements in 42 CFR §438.608 to detect and prevent potential Fraud, Waste and Abuse activities. This plan at a minimum, must include:
  - (1) Procedures and a system with dedicated staff for:
    - (a) Routine internal monitoring and auditing of compliance risks;
    - (b) Prompt response to compliance issues as they are raised;
    - (c) Investigation of potential compliance problems as identified in the course of self-evaluation and audits;
    - (d) Correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence;
    - (e) Ongoing compliance with the requirements under the contract;
    - (f) Risk evaluation procedures to monitor compliance in identified problem areas such as claims, Prior Authorization, service verification, utilization management and quality review;
    - (g) The development and implementation of an annual plan to audit network providers and validate the accuracy of encounter claims data against provider charts;
    - (h) Procedures to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by enrollees and the application of such verification processes on a regular basis;
    - (i) A system in place to receive, record, and respond to compliance questions, or reports of potential or actual non-compliance from employees and subcontractors, while maintaining confidentiality;
    - (j) A mechanism for a network provider to report an overpayment to Contractor and to return the overpayment within 60 calendar days after the date on which the overpayment was identified, and to notify the Contractor in writing, the reason for the overpayment;



Deliverable	Deliverable Date
Assessment of Compliance Activities	January 31, 2021

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

**11. Fraud Waste and Abuse Policies**

- a. Contractor shall develop Fraud, Waste and Abuse policies and procedures, and implement a mandatory compliance plan, in accordance with OAR 410-120-1510, 42 CFR §433.116, 42 CFR §438.214, 438.600 to 438.610, 438.808, 42 CFR§ 455.20, 455.104 through 455.106 and 42 CFR §1002.3, which enable the Contractor or its Subcontractors or Participating Providers to prevent and detect Fraud, Waste and Abuse activities in the Medicaid system. These policies, at a minimum, must include:
  - (1) Written standards of conduct for Contractor’s employees and Subcontractors that demonstrate compliance with all applicable requirements under the Contract, and that articulate Contractor’s commitment to comply with all applicable federal and State laws;
  - (2) A designated Chief Compliance Officer who is responsible for developing and implementing related policies, procedures and practices, and who reports directly to the CEO and the Board of Directors;
  - (3) The establishment of a Regulatory Compliance Committee at the Board of Directors and senior management level charged with overseeing the Contractor’s compliance program and its compliance with the requirements under this Contract;
  - (4) A system to provide training and education for the Compliance Officer, the organization’s senior management, and the organization’s employees and Subcontractor for the Federal and State standards and requirements under this contract;
  - (5) A system to provide education to credentialing and contracting staff including provisions prohibiting the employment of sanctioned individuals by Contractor and its Subcontractors;
  - (6) Systems designed to maintain effective lines of communication between Contractor’s compliance office and Contractor’s employees;
  - (7) A description of Contractor’s disciplinary guidelines used to enforce compliance standards and how those guidelines are publicized;
  - (8) Systems to respond promptly to allegations of improper or illegal activities and enforcement of appropriate disciplinary actions against employees or Subcontractors who have violated Fraud, Waste and Abuse policies or applicable federal or state statutes, regulations, federal or state health care requirements;
  - (9) Information in the employee handbook for the Contractor’s employees and in written policies for its Subcontractors, including a specific discussion of the applicable Fraud, Waste and Abuse Federal and State laws, the rights of employees to be protected as whistleblowers, and the Contractor’s policies and procedures for detecting and preventing Fraud, Waste and Abuse; and

- (10) A procedure for submitting these policies annually to the OHA’s Contract Administrator and other appropriate bodies charged with responsibility of operating and monitoring the Fraud, Waste and Abuse program.

**12. Review of Compliance Plan and Fraud, Waste and Abuse Policies**

- a. Contractor shall review and update its Compliance Plan and Fraud, Waste and Abuse policies annually and submit a written copy to OHA Contract Administration Unit. After review, OHA will notify Contractor within 30 calendar days of the compliance status. Contractor shall modify and resubmit policies or procedures deemed out of compliance until OHA determines that they meet applicable state and federal regulations. Copies must be submitted as follows:
  - (1) To the OHA Contract Administration Unit annually, no later than January 31<sup>st</sup>. Or attest to no changes since last submission using the Attestation form located on the CCO forms page.
  - (2) To the OHA Contract Administration Unit upon any significant changes, prior to formal adoption of the policy. OHA will notify Contractor within 30 days of the compliance status of the policy.
  - (3) To the OHA Contract Administration Unit anytime upon OHA request. OHA will notify Contractor within 30 days of the compliance status of the policy.

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

- a. Contractor may collect and retain overpayments Contractor recovers from a Provider as a result of its investigation or audit where such recoveries are the result of waste or abuse.
- b. If an investigation resulted in a fraud referral to OHA and the Department of Justice Medicaid Fraud Control Unit, the Contractor must obtain written authorization from OHA prior to the initiation of any recovery due to fraud or potential fraud.
- c. Contractor shall report all identified and recovered overpayments on the Exhibit L Financial Reporting Template.
- d. Contractor shall adjust, void or replace, as appropriate, each encounter claim to reflect the proper claim adjudication.
- e. Contractor shall maintain records of Contractor’s actions and Subcontractors’ actions related to overpayment recovery, and make those records available for OHA review upon request.
- f. Examples of overpayment types 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;
  - (5) Receipt of Medicaid payment when another payer had the primary responsibility for payment, and is not included in an automated TPL retroactive recovery process;
  - (6) Recoveries due to waste or abuse as found in audits, investigations or reviews; or
  - (7) Credit balance recoveries.

- g.** This provision does not apply to any amount of a recovery to be retained under False Claims Act cases, fraud cases, or through government investigations, such as amounts recovered by the OHA and the Medicaid Fraud Control Unit.

#### **14. Audits of Network Providers**

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

#### **15. Referral Policy**

- a.** Contractor shall promptly refer all suspected cases of Fraud, Waste and Abuse, including suspected fraud committed by its employees and Subcontractors to the Medicaid Fraud Control Unit (MFCU) and the OHA Program Integrity Audit Unit (PIAU) in accordance with 42 CFR 455.23.
- b.** Contractor shall refer such suspected cases of fraud within 7 business days.
- c.** Contractor shall ensure its Member handbook reflects information on how to report fraud, waste and abuse.
  - (1)** Examples of Fraud, Waste and Abuse within Contractor's network may include:
    - (a)** Providers who consistently demonstrate a pattern of intentionally reporting encounters or services that did not occur. A pattern would be evident in any case where 20% or more of sampled or audited services are not supported by documentation in the Clinical Records. This would include any suspected case where it appears that the Provider knowingly or intentionally did not deliver the service or goods billed;
    - (b)** Providers who consistently demonstrate a pattern of intentionally reporting overstated or up coded levels of service. A pattern would be evident by 20% or more of sampled or audited services that are billed at a higher-level procedure code than is documented in the Clinical Records;
    - (c)** Any suspected case where the Provider intentionally or recklessly billed Contractor more than the usual charge to non-Medicaid recipients or other insurance programs;
    - (d)** Any suspected case where the Provider purposefully altered, falsified, or destroyed Clinical Record documentation for the purpose of artificially inflating or obscuring his or her compliance rating or collecting Medicaid payments otherwise not due. This includes any deliberate misrepresentation or omission of

- fact that is 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;
- (e) Providers who intentionally or recklessly make false statements about the credentials of persons rendering care to Members;
  - (f) Primary Care Physicians who intentionally misrepresent medical information to justify referrals to other networks or out-of-network Providers when they are obligated to provide the care themselves;
  - (g) Providers who intentionally fail to render Medically Appropriate Covered Services that they are obligated to provide to Members under their Subcontracts with the Contractor and under OHP regulations;
  - (h) Providers who knowingly charge Members for services that are Covered Services or intentionally balance-bill a Member the difference between the total fee-for-service charge and Contractor's payment to the Provider, in violation of OHA rules;
  - (i) Any suspected case where the Provider intentionally submitted a claim for payment that already has been paid by OHA or Contractor, or upon which payment has been made by another source without the amount paid by the other source clearly entered on the claim form, and receipt of payment is known to the Provider; and
  - (j) Any case of theft, embezzlement or misappropriation of Title XIX or Title XXI program money.
- (2) Examples of Fraud, Waste and Abuse in the administration of the OHP program may include:
- (a) Evidence of corruption in the Enrollment and Disenrollment process, including efforts of State employees or Contractors to skew the risk of unhealthy patients toward or away from one of the Contractors; and
  - (b) Attempts by any individual, including employees and elected officials of the State, to solicit kickbacks or bribes, such as a bribe or kickback in connection with placing a Member into a carved out program, or for performing any service that the agent or employee is required to provide under the terms of his employment.
- (3) If Contractor is made aware of a credible allegation of Fraud by MFCU, or of a pending investigation against a Provider, Contractor shall, upon notification of an investigation by MFCU, suspend payments to the Provider unless MFCU determines there is good cause not to suspend payments or to suspend payments in part.
- (4) If the act does not meet the good cause criteria, the Contractor shall work with the MFCU and OHA to determine if any Participating Provider contract should be terminated.

## 16. Reporting Fraud, Waste and Abuse

- a. Contractor shall report to the MFCU an incident with any of the referral characteristics listed in Section 15, above. Contractor shall report to the MFCU and OHA PIAU any other incident found to have characteristics which indicate Fraud or Abuse which Contractor has verified as credible.

- b.** Contractor shall comply with all patient abuse reporting requirements and fully cooperate with the State for purposes of ORS 124.060 et seq., ORS 419B.010 et seq., ORS 430.735 et seq., ORS 441.630 et seq., and all applicable Administrative Rules. Contractor shall ensure that all Subcontractors comply with this provision.
- c.** Contractor must report annually to OHA PIAU via the Annual FWA Report:
  - (1)** Number of complaints of Fraud, Waste and Abuse made to the OHA PIAU or the Medicaid Fraud Control Unit that warrant preliminary investigation; and
  - (2)** For each matter that warrants investigation, the following:
    - (a)** Name, and Member ID number
    - (b)** Source of complaint
    - (c)** Type of Provider
    - (d)** Nature of complaint
    - (e)** Approximate dollars involved
    - (f)** Legal and administrative disposition of the case
- d.** Contractor must report quarterly to OHA PIAU via the Quarterly FWA Report:
  - (1)** A summary of recovered overpayments;
  - (2)** Any sanctions or fines administered by the Contractor;
  - (3)** Details of FWA investigations and audits; and
  - (4)** Any other information requested in the reporting template.
- e.** **Where to Refer a Case of Fraud or Abuse by a Provider**
  - Medicaid Fraud Control Unit (MFCU)**  
Oregon Department of Justice  
100 SW Market Street  
Portland, OR 97201  
Phone: 971-673-1880  
Fax: 971-673-1890
  - OHA Program Integrity Audit Unit (PIAU)**  
3406 Cherry Ave. NE  
Salem, OR 97303-4924  
Phone: 503-378-8113  
Fax: 503-378-2577  
Hotline: 1-888-FRAUD01 (888-372-8301)
- f.** **Obligations to Assist the MFCU and OHA**
  - (1)** Contractor shall permit the MFCU or OHA PIAU or both to inspect, evaluate, or audit books, records, documents, files, accounts, and facilities maintained by or on behalf of Contractor or by or on behalf of any Subcontractor, as required to investigate an incident of Fraud, Waste and Abuse.
  - (2)** Contractor shall cooperate, and requires its Subcontractors to cooperate, with the MFCU and OHA PIAU investigator during any investigation of Fraud or Abuse.

- (3) In the event that Contractor reports suspected subcontractor Fraud or Abuse, or learns of an MFCU or OHA PIAU investigation, Contractor should not notify or otherwise advise its Subcontractors of the investigation. Doing so may compromise the investigation.
- (4) Contractor shall provide copies of reports or other documentation, including those requested from the Subcontractors regarding the suspected Fraud or Abuse at no cost to MFCU or OHA PIAU during an investigation.

**g. How to Refer a Case of Fraud or Abuse by a Member**

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

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

**h. Abuse Reporting and Protective Services**

- (1) Contractor shall comply, and shall require its Participating Providers to comply, with all protective services, investigation and reporting requirements described in OAR 407-045-0000 through 407-045-0370 and ORS 430.735 through 430.765. This includes all patients observed in an office setting. Examples of abuse and neglect:
  - (a) Any Provider who hits, slaps, kicks, or otherwise physically abuses;
  - (b) Any Provider who sexually abuses;
  - (c) Any Provider who intentionally fails to render Medically Appropriate care, as defined in this Contract, by the OHP Administrative Rules and the standard of care within the community in which the Provider practices. If the Provider fails to render Medically Appropriate care in compliance with the Member's decision to exercise his or her right to refuse Medically Appropriate care, or because the Member exercises his rights under Oregon's Death with Dignity Act or pursuant to Advance Directives, such failure to treat the Member shall not be considered patient abuse or neglect; and
  - (d) Any Provider, e.g. residential counselors for developmentally disabled or personal care Providers, who deliberately neglects their obligation to provide care or supervision of vulnerable persons who are Members (children, the elderly or developmentally disabled individuals).

## **Exhibit B –Statement of Work - Part 10– Quality, Transformation, Performance Outcomes and Accountability**

### **1. Overview**

Improving access and quality while reducing the growth rate of per capita costs are key components of Health System Transformation, and measurement is necessary to determine whether the goal of advancing the Triple Aim is met. To this end, initial and ongoing data collection, analysis, and follow-up action are required of Contractor. Contractor’s obligations under the Transformation and Quality Amendment are obligations under this Contract. The purpose of this Exhibit B- Statement of Work Part 9 is to set forth the procedure Contractor shall follow to maintain the Transformation and Quality Strategy, ongoing performance measurement, and requirements for compliance with state and federal regulations for quality monitoring.

### **2. Transformation and Quality Strategy Requirements**

- a.** Contractor shall maintain a Transformation and Quality Strategy (TQS) throughout the term of this contract. Contractor’s strategy must include, at minimum, the components of Quality Assurance and Performance Improvement Program (QAPI), in accordance with 42 CFR 438.330 and health transformation.
- b.** The Transformation and Quality strategy identifies the goals, objectives and intended outcomes for the annual QAPI program, including the health innovation transformation activities. The TQS template includes project and the goal with enough detail to demonstrate and monitor performance improvement.
- c.** Transformation and Quality Strategy submission section requirements:  
  
The TQS guidance document details the TQS content and attachments required for submission. TQS guidance document will be updated annually and posted no later than October 1. All TQS information and resources are posted on the OHA Transformation Center TQS website. <https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Transformation-Quality-Strategy.aspx>
- d.** Transformation and Quality Strategy template and progress report templates provided by OHA will be required for submission by contractor. Details of the aforementioned will be available on the OHA Transformation website <https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Transformation-Quality-Strategy.aspx>
- e.** Contractor shall have in effect a process for its own evaluation of the impact and effectiveness of its systems interventions of its quality program.
- f.** Contractor will include the basic elements of a QAPI Subsections (1) through (8) of paragraph g. below, in the annual QAPI program evaluation; however, these are not intended to be the only QAPI activities reported. Contractor shall include in its annual QAPI program evaluation all system activities utilized to implement and ensure quality coordinated health care, including behavioral health and oral health care.
- g.** Contractor shall include in the annual QAPI program evaluation:
  - (1)** As per OAR 410-141-0200, contractor shall have a quality committee to oversee QAPI and transformation program. Such committee serves as structure for quality and transformation. An internal quality improvement committee that monitors the annual quality strategy and work plan;
  - (2)** An internal Utilization Review oversight committee that monitors utilization against practice guidelines and treatment planning protocols and policies. Contractor shall have

- in effect mechanisms to: (i) detect both under-utilization and over-utilization of services; (ii) to document the findings; (ii) to report aggregate data indicating the number of enrollees identified (iv) and to describe follow-up actions for both findings;
- (3) An assessment of the quality and appropriateness of care furnished to all Members, availability of services, second opinions, timely access and cultural considerations, with a report of aggregate data indicating methods used to monitor compliance;
  - (4) An assessment of the quality and appropriateness of care furnished to Members with special health care needs, with a report of aggregate data indicating the number of enrollees identified and methods used to evaluate the need for direct access to specialists;
  - (5) A demonstration of improvement in an area of poor performance in care coordination for Members with Serious and Persistent Mental Illness, with a report of aggregate data indicating the number of Members identified and methods used;
  - (6) A report on the grievance system inclusive of complaints, notice of actions, appeals and hearings,
  - (7) Monitoring and enforcement of consumer rights and protections within the Oregon Integrated and Coordinated Health Care Delivery System that ensures consistent response to complaints of violations of consumer rights and protections;
  - (8) Participation as a member of the OHA Quality and Health Outcomes Committee (QHOC).

### **3. Revised Transformation and Quality Strategy**

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

### **4. Transformation and Quality Strategy Monitoring and Compliance Review**

Contractor agrees to progress toward achieving the objectives and timelines identified in its Transformation and Quality Strategy and areas of transformation and to demonstrating progress consistent with the Strategy and Areas of Transformation. OHA will monitor Contractor's compliance with the requirements in its Strategy and areas of transformation and with other elements of Quality, Health System Transformation in the Statement of Work. Contractor shall make records and facilities available for OHA's compliance review, consistent with Exhibit D, Section 13 of this Contract.

The requirements of this Exhibit B – Part 9 are in addition to any other requirements in this Contract for timeliness, accuracy and completeness of data reporting required to be submitted under the Contract, including but not limited to encounter data, paid claims data, and data related to performance and quality outcome measures.

OHA will monitor Contractor's progress in achieving its Transformation and Quality Strategy and areas of transformation. If OHA cannot confirm Contractor's progress toward compliance with its Strategy and Areas of Transformation, OHA will notify and give the Contractor the opportunity to demonstrate evidence of progress and compliance with its Strategy and Areas of Transformation before seeking to impose Sanctions under this Contract, and to pursue other remedies available under this Contract.

## 5. Transformation and Quality Strategy Deliverables

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

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

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

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

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

## 6. Goals for Transformation and Quality Strategy Amendments

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

## 7. Quality and Performance Outcomes

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

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

- a. Measure and report to OHA its performance, using standard measures required by OHA; and
- b. Submit data specified by OHA, that enables OHA to measure the Contractor's performance;

## 8. Performance Measurement and Reporting Requirements

Contractor shall plan for and implement the necessary organizational infrastructure to address performance standards established for this Contract, as follows:

- a. "Reporting Year" shall be the calendar year: January 1 through December 31.
- b. In each Reporting Year, Contractor is accountable for timely, complete and accurate submission and reporting of encounter data.
- c. Performance relative to targets affects Contractor's eligibility for financial and non-financial rewards.
- d. OHA's Metrics and Scoring Committee will revise and adopt measures, benchmarks and improvement targets that will apply to the quality incentive program. To the greatest extent possible, measures will be based on national standards.

- e. Timely reporting serves as the basis for holding Contractor accountable to contractual expectations. OHA will assess Contractor performance more frequently (e.g. quarterly or semi-annually) on an informal basis to facilitate timely feedback, mid-course corrections, and rapid improvement recommendations to Contractor. The Parties shall document any changes agreed to as part of these assessments.
- f. The performance measures reporting requirements will measure the quality of health care and services, during a time period in which Contractor was providing Covered Services. The performance measures reporting requirements expressly survive the expiration, termination or amendment of this Contract, even if Contract expiration, termination or amendment results in a termination or modification of this Contract or a modification or reduction of the Enrollment or Service Area.
- g. Contractor shall include any additional measures requested by CMS from its Adult Medicaid and CHIPRA core measure sets.
- h. Metrics that are applicable to this Contract for each contract year are found at: <http://www.oregon.gov/oha/Pages/CCO-Baseline-Data.aspx>.
- i. By October 1 of each Year, OHA will issue the list of Quality Incentive measures and benchmarks, as well as the structure of the Quality Pool described in Section 13 of this Exhibit B, Part 9, (Quality Pool Methodology) for the subsequent year. These measures, benchmarks, and methodology will be used for the subsequent measurement year of the Quality Incentive Program. Payment for performance would be awarded from the Quality Pool in the year following the measurement year. For example, measures, benchmarks, and methodology document for 2020 will be published by October 1, 2019, and CCOs will receive payment for CY 2020 performance by June 30, 2021. All documentation will be made available online at <http://www.oregon.gov/oha/Pages/CCO-Baseline-Data.aspx>.

## 9. Quality Performance Improvement Projects

- a. Contractor shall have an ongoing program of performance improvement projects (PIPs) that are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical and non-clinical areas that are expected to improve health outcomes and OHP Member satisfaction. Contractor's ongoing program of quality PIPs shall include the following:
  - (1) Measurement of performance using objective quality indicators;
  - (2) Implementation of system interventions to achieve improvement;
  - (3) Evaluation of the effectiveness of the interventions; and
  - (4) Planning and initiation of activities for increasing or sustaining improvement.
- b. Contractor shall commit to improving care in at least 4 of the following 7 focus areas. Contractor shall participate in focus area (4), below, as a statewide PIP. Contractor shall select an additional 2 projects from the list below, to serve as the Contractor's Performance Improvement Projects in accordance with 42 CFR §438.358 and 438.330(a)(2). Contractor shall cover the 4<sup>th</sup> of 7 focus areas through a focus study project. CMS, in consultation with OHA and other stakeholders may specify performance measures and topics for performance improvement projects to be required by OHA in this Contract. Contractor's selected focus areas should align with the quality and incentive requirements for CCOs issued by OHA and the Contractor's Quality and Transformation Strategy to the extent feasible.
  - (1) Reducing preventable re-hospitalizations.

- (2) Addressing population health issues (such as diabetes, hypertension and asthma) within a specific geographic area by harnessing and coordinating a broad set of resources, including Traditional Health Workers, public health services, and aligned federal and state programs,
  - (3) Deploying primary care teams to improve care and reduce preventable or unnecessarily costly utilization by “super-users,”
  - (4) Statewide PIP: Integrating primary care, behavioral care and/or oral health,
  - (5) Ensuring appropriate care is delivered in appropriate settings,
  - (6) Improving perinatal and maternity care,
  - (7) Improving primary care for all populations through increased adoption of the PCPCH model of care throughout the Contractor’s network, and
  - (8) Social Determinants of Health and Health Equity.
- c. Each PIP must be completed in a reasonable time period as to generally allow information on the success of PIP(s) in the aggregate to produce new information on quality every reporting year, as defined in this Exhibit B, Part 9.
- d. Contractor must report the status and results of each project quarterly to OHA. Reports are due April 30, July 31, October 31 and January 31 for the preceding calendar quarter work.

## 10. Program Requirements

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

## 11. External Quality Review

- a. In conformance with 42 CFR§438.350 and 438.358, and 42 CFR §457.1250. Contractor shall cooperate and shall require its Subcontractors and Participating Providers to cooperate with OHA by providing access to records and facilities, and sufficient information for the purpose of an annual external, independent professional review of CCO compliance with all applicable state and federal rules, the CCO contract with OHA and of the quality outcomes and timeliness of, and access to, Services provided under this Contract.
- b. If an External Quality Review Organization (EQRO) identifies an adverse clinical situation in which follow-up is needed to determine whether appropriate care was provided, the EQRO will report the findings to OHA and Contractor.
- c. Consistent with 42 CFR§438.10 and 438.350, OHA will:
- (1) Implement an EQR protocol following CMS protocols required by 42 CFR §438.352 and provide to Contractor, prior to review conducted of Contractor, and the EQRO follow that protocol;
  - (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;
- d. Require EQRO to meet competence and independence requirement in 42 CFR §438.354; and

- e. Require an EQRO to produce the report and information required by 42 CFR §438.364 and to promptly provide such information to Contractor when complete.
- f. Ensure that EQR results are made available, as required in 42 CFR §438.364, in an annual detailed technical report that summarizes findings on access and quality of care. The most recent copy of the annual EQR technical report will be posted on OHA Web site as required under 42 CFR §438.10(c)(3) by April 30th of each year and provide printed or electronic copies, upon request.
  - (1) Consistent with 42 CFR §438.350, 438.358, and 457.1250 the EQRO will:
    - (a) Conduct EQR of CCOs contracted with the State for the delivery of services covered under Medicaid.
    - (b) Perform an EQR which shall include, at a minimum, the elements in 42 CFR §438.364(a)(2)(i) through (iv).
    - (c) Mandatory activities, described in 42 CFR §438.358(b), will be assessed by the EQRO in a matter consistent with protocols established by CMS, for each EQR element
    - (d) Additional EQR activities, described in 42 CFR §438.358(c), shall be reviewed by the EQRO as negotiated by OHA and EQRO.
    - (e) EQR review timeline will adhere to CMS requirements under 42 CFR §438.358.
  - (2) The EQRO may, at the OHA’s direction, provide technical guidance to groups of CCOs to assist them in conducting activities related to the mandatory and additional activities described in 42 CFR §438.358 that provide information for the EQR and the resulting EQR technical report.
  - (3) Contractor shall address and require its subcontractors or delegated entities to address any findings or recommendations identified in EQR reports in a manner designed to correct the deficiency within a timeline acceptable to OHA.

## 12. Quality Pool

- a. OHA has implemented a Quality Pool, based the outcome and quality measures adopted by the Metrics and Scoring Committee. The Quality Pool is a payment mechanism that rewards all participating CCOs that demonstrate quality of care provided to their Members as measured by their performance or improvement on the outcome and quality measures. The whole Quality Pool is at risk for performance. Total quality payments in the aggregate by OHA are subject to a maximum percentage specified in the CCO capitation rate certification (see Exhibit C).. The Quality Pool process will not alter OHA’s authority to administer the Encounter Data and quality reporting requirements or any other provisions under the Contract.
- b. Contractor will receive a monetary incentive payment from the Quality Pool based on its measured performance or improvement in a calendar year, based on measures selected by the Metrics & Scoring Committee and specifications published by OHA for the Reporting Year. OHA will publish further instructions about the methodology for distributions from the Quality Pool (the “Reference Instructions”) along with the other information described in this section. The final measure specifications and the Reference Instructions for Measurement Years will be published at: <http://www.oregon.gov/oha/analytics/pages/cco-baseline-data.aspx>
- c. **Aggregate Amount**

- (1) The Quality Pool in aggregate among all CCOs for a Measurement Year will be at least the sum of 2 percent of the aggregate of CCO Payments made to all CCOs for the Measurement Year paid through March 31 of the Distribution Year, excluding any Quality Pool payments made relating to the prior year. Final determination of the Quality Pool size will be published in the Reference Instructions.
- (2) The entire Quality Pool will be disbursed annually to CCOs by June 30 of the Distribution Year.

**e. Metrics**

- (1) For the eighth Measurement Year (CY 2020), CCO performance is based on XX Incentive Measures, specified at <http://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Baseline-Data.aspx> Measure specifications and methodology for the fourth Measurement Year (CY2020) will be documented at <http://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Baseline-Data.aspx>.
- (2) The number and description of the Incentive Measures, their specifications and operationalization, and which Incentive Measures are tied to the Quality Pool, are subject to change for future Measurement Years, at the discretion of the Metrics & Scoring Committee and subject to CMS approval.

**f. Performance**

- (1) CCOs will be rewarded for meeting the Incentive Measures.
- (2) Each Incentive Measure has certain criteria that Contractor must meet to achieve that Incentive Measure . OHA will annually publish an updated Quality Pool Methodology and measure specifications with the criteria needed to quality on a given measure at [.http://www.oregon.gov/OHA/HPA/ANALYTICS/Pages/CCO-Baseline-Data.aspx](http://www.oregon.gov/OHA/HPA/ANALYTICS/Pages/CCO-Baseline-Data.aspx)
- (3) For each Measurement Year, except as OHA specifies a different method of scoring, Contractor will be measured against the Incentive Measure on a pass or fail basis, and Contractor will pass an Incentive Measure if it meets either the Benchmark or the Improvement Target. For certain Incentive Measures, OHA may specify scoring on a tiered basis or on the basis of ability to report clinical data.

**g. Distributions**

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

**h. Data and Reporting**

- (1) OHA is responsible for calculating, producing, and validating Contractor’s performance on each of the Incentive Measures.
- (2) Contractor is responsible for:

Timely and accurate submission of claims, encounter, PCPCH enrollment, and clinical data including medical record data to support hybrid measures and electronic medical record data for clinical measures per requirements of this Contract; and

- (3) The performance of Contractor and all other CCOs for each Measurement Year will be based on claims and data for Dates of Service within the Measurement Year submitted to OHA through the last business day of March of the Distribution Year. Claims and data for Dates of Service in a Measurement Year submitted to OHA after the last business day of March of the Distribution Year will not be included in the Incentive Measure calculation.
- (4) OHA will provide Contractor with its final Incentive Measure calculations for review no later than April 30 of the Distribution Year. Contractor will have until May 31 of the Distribution Year to review and comment on final Incentive Measure calculations for the preceding Measurement Year.
- i. Contractor shall offer correlative arrangements with Participating Providers (including Social Determinants of Health & Health Equity partners, public health partners, and other health-related services providers as appropriate), providing monetary incentive payment arrangements with Providers that reflect priorities which align with the Quality Pool program for achieving the outcome and quality objectives. Contractor shall report these arrangements and amounts paid to OHA annually, on Exhibit L and submitted in conjunction with the 4<sup>th</sup> Quarter reporting period (See Exhibit L).
- j. Prior Measurement Years data are available online at <http://www.oregon.gov/oha/metrics/pages/HST-Reports.aspx>.
- k. Contractor shall create a distribution plan for Quality Pool and Challenge Pool earnings. The plan should include:

  - (1) an overview of the methodology and/or strategy used to distribute quality pool earnings to participating providers, including Social Determinants of Health and Health Equity (SDOH-HE) and public health partners, that provides information related to the contractor's process of evaluating the contributions of participating providers and connecting those evaluations to distribution of funds; .
  - (2) data on the expenditure of quality incentive pool earnings and whether the distribution considers payments made previously to participating providers (such as up front funding to a clinic or non-clinical partner that is intended to help the contractor achieve metrics related to the quality pool);
  - (3) information to help participating providers (including SDOH-HE and public health partners) understand how they may qualify for payments, how contractor distributed funds in the most recent year, and how they may distribute funds in future years.
- l. The distribution plan, should be provided to OHA and made publicly available each year within 60 days of the contractor's receipt of its final quality pool distribution.

## Exhibit C – Consideration

### 1. Payment Types and Rates

- a. In consideration of all the Work to be performed under this Contract, OHA will pay Contractor a monthly CCO Payment for each Member enrolled under the Contract according to OHA records. The monthly CCO Payment rate authorized for each Member is that amount indicated in Attachment 1 to this Exhibit C, CCO Rates, for each Member’s Rate Group as “Total Services with Admin and Taxes.” OHA withholds a portion of the capitation as part of the Quality Incentive Pool program (Exhibit B), which is paid separately based on quality metrics achieved. OHA will prorate the CCO Payment for Members who are enrolled mid-month. OHA may withhold payment for new Members when, and for so long as, OHA determines that Contractor meets the circumstances cited in 42 CFR 438.700 et seq.
- b. The monthly CCO Payment may include risk adjustment based on diagnosis or health status and will include a risk corridor in accordance with Section 6 of this Exhibit C.
- c. In addition to the CCO Payment rate paid to Contractor, Contractor shall make qualified directed payment to hospital for the amounts indicated in a monthly report created by OHA to assist Contractors in distributing Quality and Access funds to the appropriate hospital. .
- d. As described in OAR 410-141-3420(10)-(12), OHA may require Contractor to continue to reimburse a Rural Type A Hospital or Rural Type B Hospital for the cost of Covered Services based on a Cost-to-Charge Ratio. This section does not prohibit Contractor and a Hospital from mutually agreeing to reimbursement arrangements.
- e. If Contractor has a contractual relationship with a designated Type A, Type B, or Rural critical access Hospital, the Contractor and each said Hospital shall provide representations and warranties to OHA:
  - (1) That said contract establishes the total reimbursement for the services provided to persons whose medical assistance benefits are administered by the Contractor; and
  - (2) That Hospital reimbursed under the terms of said contract is not entitled to any additional reimbursement from OHA for services provided to persons whose medical assistance benefits are administered by Contractor.

### 2. Payment in Full

The consideration described in this Exhibit C is the total consideration payable to Contractor for all work performed under this Contract. OHA shall ensure that no payment is made to a provider other than the Contractor for services available under the Contract between OHA and the Contractor, except when these payments are specifically provided for in Title XIX of the Social Security Act.

### 3. Changes in Payment Rates

The CCO Payment Rates may be changed only by amendment to this Contract pursuant to Exhibit D, Section 20 of this Contract.

- a. Changes in the CCO Payment Rates as a result of adjustments to the Service Area or to the Enrollment limit may be required pursuant to Exhibit B, Part 4, Section 11 of this Contract.
- b. The CCO Payments authorized to be paid under this Contract are based on the funded condition-treatment pairs on the Prioritized List of Health Services in effect on the date this Contract is executed, subject to the terms of this Contract.

- (1) Pursuant to ORS 414.690, the Prioritized List of Health Services of Condition/Treatment Pairs developed by the Health Evidence Review Commission may be expanded, limited or otherwise changed. Pursuant to ORS 414.690 and 414.735, the funding line for the services on the Prioritized List of Health Services may be changed by the Legislature.
  - (2) In the event that insufficient resources are available during the term of this Contract, ORS 414.735 provides that reimbursement shall be adjusted by eliminating services in the order of priority recommended by the Health Evidence Review Commission, starting with the least important and progressing toward the most important.
  - (3) Before instituting reductions in Covered Services pursuant to ORS 414.735, OHA is required to obtain the approval of the Legislative Assembly or the Emergency Board if the Legislative Assembly is not in session.
  - (4) If legislative scheduling permits, OHA will notify Contractor at least two weeks prior to any legislative consideration of such reductions in Covered Services pursuant to ORS 414.735(3).
  - (5) Adjustments made to the Covered Services pursuant to ORS 414.735 during the term of this Contract will be referred to the actuary who is under contract with OHA for the determination of CCO Payment Rates. The actuary will determine any rate modifications required as the result of cumulative adjustments to the funded list of Covered Services based on the totality of the OHP rates for all Contractors (total OHP rates).
    - (a) For changes made during the first year of the two year per capita cost period since the list was last approved by the Legislative Assembly or the Emergency Board, the actuary will consider whether changes are covered by the trend rate included in the existing total OHP rate(s) and, thus, not subject to adjustment or are services moved from a Non-Covered Service to a Covered Service.
    - (b) If the net result under Paragraph (5) or (5) (a) above for services subject to the adjustment is less than 1% of the total OHP rates, no adjustment to the CCO Payment Rates will be made.
    - (c) If the net result under Paragraph (5) or (5) (a) above is 1% or greater of the total OHP rates, the CCO Payment Rates will be amended pursuant to Exhibit D, Section 20 of this Contract.
    - (d) The assumptions and methodologies used by the actuary to determine whether the net result is more or less than 1% shall be made available to Contractor.
  - (6) Notwithstanding the foregoing, Subsections b (1) through (5) do not apply to reductions made by the Legislative Assembly in a legislatively adopted or approved budget.
- c. This paragraph applies to any change to the CCO Payment Rates made by a Contract amendment that has retroactive effect or that cannot be implemented before the next regularly scheduled date for payment. If such change increases the CCO Payment owed by OHA to Contractor, then OHA will make a payment to Contractor, by one-time adjustment to a future regularly scheduled Capitation Payment or by separate payment. If such change decreases the CCO Payment owed by OHA to Contractor, then such decrease will be subject to the provisions of this Contract governing overpayments.

#### **4. Timing of CCO Payments**

- a. The date on which OHA will process CCO Payments for Contractor's Members depends on whether the Enrollment occurred during a weekly or monthly Enrollment cycle. OHA will

provide a schedule of Enrollment end of month deadlines for each month of the Contract period. On months where the first of the month falls on a Friday, Saturday or Sunday, CCO Payments will be made available to the Contractor no later than the 11th day of the month to which such payments are applicable.

- (1) Weekly Enrollment: For Clients enrolled with Contractor during a weekly Enrollment cycle, CCO Payments will be made available to Contractor no later than two weeks following the date of Enrollment, except for those occurrences each year when the weekly and monthly Enrollment start date are the same day.
  - (2) Monthly Enrollment: For Clients enrolled with Contractor during a monthly Enrollment cycle, CCO Payments shall be made available to Contractor by the 10<sup>th</sup> day of the month to which such payments are applicable, except for those occurrences each year when the weekly and monthly CCO Payments coincide with each other.
- b. Both sets of payments described in Subsection a, of this section shall appear in the weekly/monthly 820 Group Premium Payment (Capitation) Transaction and in the weekly 835 Payment/Remittance Advice Transaction. To assist Contractor with Enrollment and CCO Payment/Remittance Advice reconciliation, OHA will include in the weekly/monthly 820 Group Premium Payment (Capitation) Transaction the original adjustment amount and the paid amount for each of Contractor's Members. The inclusion of this information does not ensure or suggest that the two transaction files will balance. If Contractor believes that there are any errors in the Enrollment information, Contractor shall notify OHA. Contractor may request an adjustment to the Remittance Advice no later than 18 months from the affected Enrollment period.
  - c. OHA will make retroactive CCO Payments to Contractor for any Member(s) erroneously omitted from the Enrollment transaction files. Such payments will be made to Contractor once OHA manually processes the correction(s).
  - d. OHA will make retroactive CCO Payments to Contractor for newborn Members. Such payments will be made to Contractor by the 10<sup>th</sup> day of the month after OHA adds the newborn(s).
  - e. Services that are not Covered Services provided to a Member or for any health care services provided to fee for service Clients are not entitled to be paid as CCO Payments. Fee-for-service claims for payment must be billed directly to OHA by Contractor, its Subcontractors, or its Participating Providers, all of which must be enrolled with OHA in order to receive payment. Billing and payment of all fee-for-service claims shall be pursuant to and under OAR Chapter 410, Division 120.

## **5. Settlement of Accounts**

- a. If a Member is disenrolled, any CCO Payments received by Contractor after the effective date of Disenrollment will be considered an overpayment and will be recouped by OHA under Paragraph f. below.
- b. OHA will have no obligation to make any payments to Contractor for any period(s) during which Contractor fails to carry out any of the terms of this Contract.
- c. If Contractor requests, or is required by OHA, to adjust the Service Area or Enrollment limit or to transfer or reassign Members due to loss of Provider capacity or for other reasons, any delay in executing amendments or completing other Contract obligations pursuant to Exhibit B, Part 4, Section 11, Adjustments in Service Area or Enrollment, may result in recovery of CCO Payments to which Contractor was not entitled under the terms of this Contract.

- d.** Any payments received by Contractor from OHA under this Contract, and any other payments received by Contractor from OHA, or any other source to which Contractor is not entitled under the terms of this Contract shall be considered an overpayment and may be recovered by OHA from Contractor.
- e.** Sanctions imposed that result in Recovery Amounts pursuant to Exhibit D, Section 33 through 36 of this Contract are subject to recovery and may be recovered by OHA from Contractor.
- f.** Any overpayment or Recovery Amount under Exhibit B or C of this Contract may be recovered by recoupment from any future payments to which Contractor would be entitled from OHA, or pursuant to the terms of a written agreement with OHA, or (in the absence of sufficient future payments or written agreement) by civil action to recover the amount. OHA may withhold payments to Contractor for amounts disputed in good faith and shall not be charged interest on any payments so withheld.
- g.** OHA will recover from Contractor payments made to Contractor or to other Providers for sterilizations and hysterectomies performed where the Contractor failed to meet the requirements of Exhibit B, Part 2, Section 4(g), of this Contract, the amount of which will be calculated as follows:

  - (1)** Contractor shall, within 60 days of a request from OHA, provide OHA with a list of all Members who received sterilizations or hysterectomies, from Contractor or its Subcontractors during the Contract period and copies of the informed consent form or certification. OHA will be permitted to review the Medical Records of these individuals selected by OHA for purposes of determining whether Contractor complied with OAR 410-130-0580.
  - (2)** By review of the informed consent forms, certifications, and other relevant Medical Records of Members, OHA will determine for the Contract period the number of sterilizations and hysterectomies provided or authorized by Contractor or its Subcontractors that did not meet the requirements of Exhibit B, Part 2, Section 4(g), of this Contract.
  - (3)** Sterilizations and hysterectomies that Contractor denies for payment shall not be included in the recoupment calculation, however, they must be reported in the submission. The report of these sterilizations and hysterectomies must be accompanied by a signed statement certifying that Contractor did not make payment for the surgery or any services, which are specifically related to the procedure.
  - (4)** The number of vasectomy, tubal ligation, and hysterectomy procedures that do not meet the documentation requirements of Exhibit B, Part 1, Section 6, of this Contract, shall be multiplied by the assigned “value of service”.
  - (5)** “Value of service” for vasectomy, tubal ligation, and hysterectomy means the OHP amount calculated by OHA’s internal actuarial unit for each category of service using the encounter data.
  - (6)** The results of Paragraph (4) of this subsection will be totaled to determine Contractor’s overpayment for hysterectomies and sterilizations subject to recovery pursuant to Exhibit C, Section 5, Subsection g, of this Contract.
  - (7)** The final results of the review will be conveyed to Contractor in a timely manner within 90 days of determination.

OHA will notify Contractor of in advance of any recovery and will provide Contractor with an opportunity to appeal the recovery. Contractor may file a written objection within 14 days from the date of the notice, requesting an appeal and setting forth with specificity the grounds for appeal. Any appeal shall be conducted as an administrative review. In such administrative review, the parties agree to confer in good faith regarding the nature and amount of the overpayment in dispute and the manner in which the overpayment is to be repaid. The administrative review process will be conducted in the manner described in OAR 410-120-1580(4)-(6). Contractor understands and agrees that administrative review is the sole avenue for review of recoveries. The decision on administrative review shall result in a final Recovery Amount if an appeal was timely filed.

The requirements of this section expressly survive the termination of this Contract, and shall not be affected by any amendment to this Contract, even if amendment results in modification or reduction of Contractor's Service Area or Enrollment. Termination, modification, or reduction of Service Area does not relieve Contractor of its obligation to submit sterilization/hysterectomy documentation for dates of service applicable to Service Areas while they were paid a CCO Payment under this Contract, nor does it relieve Contractor of the obligation to repay overpayment amounts or Recovery Amounts under this section.

## **6. CCO Risk Corridor**

### **a. Operation of the CCO Risk Corridor**

Contractor shall comply with the requirements for administration of the risk corridor established in this Section. The CCO Risk Corridor utilizes specific percentages above and below a target amount, establishing "bands" of risk, which define how the Contractor and OHA will review the adjusted costs of the Expenses of Members receiving eligible services during the Risk Corridor Period, subject to settlement.

#### **(1) Hepatitis C DAA Settlements.**

- (a) Treatment of 340B utilization.** Contractor shall reimburse all Hepatitis C DAA drugs that are purchased by a 340B entity at the 340B entity's actual acquisition cost, plus the contractor's usual allowed dispensing fee. This requirement shall apply to 340B drugs that are directly dispensed by a 340B entity, as well as 340B drugs dispensed on contract by a non-340B entity.
- (b) Completion of Data Submissions.** Encounter Data for the period from January 1, 2020 through December 31, 2020 (12 months), must be submitted to OHA no later than April 30, 2021. Contractor shall submit the following information to OHA for Members receiving Hepatitis C DAA drugs for dates of service during the Hepatitis C Risk Corridor Period:
  - (i)** Timely and accurate Encounter Data for all Hepatitis C DAA drugs.
  - (ii)** A form specified by OHA, accompanied by an attestation that all Hepatitis C DAA drugs that are 340B drugs were reimbursed at the 340B entity's actual acquisition cost, plus the contractor's usual allowed dispensing fee. Any such drugs found to be in conflict with this requirement will be repriced at the 340B ceiling price, if reported cost is higher.

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

- (iii) A form specified by OHA, accompanied by an attestation that any restrictive drug list (as described in OAR 410-141-3070(3)) will, at a minimum, include the Hepatitis C DAA drugs included on the OHA-approved fee for service (“FFS”) Preferred Drug List (also known as the practitioner managed prescription drug plan or “PMPDP”). Contractor may continue to prefer additional Hepatitis C DAA drugs, so long as doing so does not conflict with any Statewide Supplemental Rebate Agreement entered into by OHA. Any drugs found to be in conflict with a Statewide Supplemental Rebate Agreement included in the Contractor’s Hepatitis C DAA data will be repriced as if the FFS preferred drug were used (net of rebates), if reported cost is higher.
- (iv) A form specified by OHA, accompanied by an attestation that all Members eligible for, and who received, Hepatitis C DAA drugs followed the same criteria and prior authorization protocol as specified in the OHA-approved coverage criteria for FFS members. The FFS criteria do not apply when Medicaid is the secondary payer. Contractor may specify alternative criteria for non-preferred PMPDP Hepatitis C DAA drugs, as long as doing so does not conflict with any Statewide Supplemental Rebate Agreements entered into by OHA.
- (v) A form specified by OHA, containing an attestation completed by Contractor that Contractor has not received and will not seek conflicting supplemental rebates for Hepatitis C DAA drugs dispensed during the Hepatitis C Risk Corridor Period. In the same form, Contractor shall also report any offsets as it relates to Hepatitis C DAA Expenses. Contractor may continue to collect supplemental rebates for Hepatitis C DAA drugs, as long as doing so does not conflict with any Statewide Supplemental Rebate Agreements entered into by OHA.
- (vi) A form specified by OHA, containing an attestation completed by Contractor detailing the care management protocol for each Member receiving DAA drugs for treatment of Hepatitis C. Prior to commencement of the Hepatitis C Risk Corridor Period, OHA will consult with the Coordinated Care Organizations to develop a definition for “adequate care management”. The definition will be posted to the Contract Reports Web Site, prior to January 1, 2020.
- (c) OHA will compare the Hepatitis C Expenses using the paid amounts reported on the Encounter Data. OHA may request additional information if needed for clarification, or if any encounters have a zero paid amounts. A settlement report in a form prepared by OHA with information about the methodology will be sent to Contractor for Encounter Data validation purposes.
- (d) Hepatitis C DAA Expenses will be compared with Hepatitis C DAA Revenue.
- (e) Hepatitis C DAA Admin Revenue will be evaluated against Contractor’s care management protocol contained in the form referenced above. Contractor will be required to return a portion of the Hepatitis C DAA Admin Revenue to OHA if OHA determines, in its sole discretion, that Contractor failed to perform adequate care management for Hepatitis C DAA Drugs.



- (ii) When Contractor’s Initial Procurement Expense for the Initial Procurement Risk Corridor Period is equal to or greater than 105 percent of the Initial Procurement Revenue, OHA will pay Contractor an amount equal to 75 percent of Initial Procurement Expense in excess of 105 percent of the Initial Procurement Revenue, and 50 percent of Initial Procurement Expense between 102 percent and 105 percent of Initial Procurement Revenue.
- (b) OHA will charge Contractor in the following amounts under the following circumstances:
  - (i) When Contractor’s Initial Procurement Expense for the Initial Procurement Risk Corridor Period are between 95 percent and 98 percent of the Initial Procurement Revenue, OHA will charge the Contractor an amount equal to 50 percent of the excess between 95 percent of the Initial Procurement Revenue and the Initial Procurement Expense; or
  - (ii) When Contractor’s Initial Procurement Expense for the Initial Procurement Risk Corridor Period are less than, or equal to, 95 percent of the Initial Procurement Revenue, the OHA will charge the Contractor an amount equal to 75 percent of the difference between the Contractor’s Initial Procurement Expense and 95 percent of the Initial Procurement Revenue; and the Contractor shall owe OHA 50 percent of Initial Procurement Revenue between the 95 percent and 98 percent corridor.
- (c) OHA will, after conferring with the Contractor about the method and timing of the payment or charge, make the payment to Contractor or require a payment from Contractor by adjusting future payments to Contractor.

**7. Global Payment Rate Methodology**

OHA has developed actuarially set Adjusted Per Capita Costs (Capitation Rates) to reimburse plans for providing the Covered Services. A full description of the methodology used to calculate per capita costs may be found in the OHA document “*“Oregon CY20 – Coordinated Care Organization Rate Certification”* (the “Actuarial Report”). The Actuarial Report is available at <http://www.oregon.gov/oha/analytics/Pages/OHPrates.aspx>. The Actuarial Report is not part of this Contract, and except where specifically referred to herein, may not be used in the interpretation or construction of this Contract.

**8. Administrative Performance Penalty**

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

**9. Quality Pool**

Upon CMS approval, Contractor will be eligible for additional payments under the Quality Pool in accordance with Exhibit B, Part 9.

**10. Minimum Medical Loss Ratio:**

- a. In accordance with CMS 42 CFR 438.8 Contractor shall maintain a Minimum Medical Loss Ratio (MMLR) of at least 85% for its total Member population and shall submit an annual certified MMLR Rebate Report which validates its compliance with this requirement.

- b.** Contractor shall meet or exceed the MMLR Standard for each Rebate Period. In the event Contractor’s MMLR falls below the MMLR Standard for a Rebate Period, Contractor shall be obligated to OHA for a Rebate.
- c.** Contractor shall file its MMLR Rebate Report electronically utilizing the Minimum Medical Loss Ratio Rebate Calculation template (Excel Workbook) and following the Minimum Medical Loss Ratio Rebate Calculation Report Instructions located on the Contract Reports Web Site as well as in accordance with CMS Rules 42 CFR 438.8 Medical Loss Ratio (MLR). All information reported on the MMLR Rebate Report must be for revenues and expenses under this Contract or a predecessor CCO contract. The MMLR Rebate Report must be certified by an officer of Contractor, under penalty of false claims act liability, in the manner required by the Minimum Medical Loss Ratio Rebate Calculation Report Instructions.
- d.** Contractor shall file its MMLR Rebate Report for each Reporting Period with OHA’s Contract Administration Unit each year by June 30 of the year following the Reporting Period based on OHA’s instructions and provided template(s).
- e.** OHA will review Contractor’s filed MMLR Rebate Report as follows;

  - (1)** If OHA determines that Contractor’s MMLR Rebate Report is complete and accurate and that Contractor’s MMLR meets the MMLR Standard, OHA will issue a final determination that no Rebate will occur for the Rebate Period.
  - (2)** If OHA determines that Contractor’s MMLR Rebate Report is incomplete or inaccurate, OHA will provide or request proposed revisions to the MMLR Rebate Report. Contractor shall supply any information requested by OHA in connection with the MMLR Rebate Report within 10 Business Days of the request. The revised MMLR Rebate Report will become final for purposes of the MMLR calculations 10 Business Days after the date of the revisions, unless OHA receives from Contractor a written notice of appeal for the applicable Reporting Period not later than 10 Business Days after the date of the revisions. The notice of appeal from the Contractor must include written support for the appeal.
  - (3)** Any appeal shall be conducted as an administrative review. The administrative review process will be conducted in the manner described in OAR 410-120-1580(3)-(6). Contractor understands and agrees that administrative review is the sole avenue for review of the MMLR Rebate Reports that it has appealed. The decision on administrative review will result in a final MMLR Rebate Report if an appeal was timely filed.
  - (4)** OHA will rely upon the final MMLR Rebate Report to determine whether the Contractor is subject to a Rebate for the Rebate Period and the amount of any Rebate.
  - (5)** OHA will conduct this review, verifying the Rebate, if any, and notifying the Contractor no later than December 31 of the year in which the MMLR Rebate Report is filed.
- f.** OHA will confirm with Contractor any Rebate to OHA required due to an MMLR not meeting the MMLR Standard. If a Rebate is due to OHA, the amount will be offset against future CCO Payments.

**Exhibit C – Consideration - Attachment 1 – CCO Payment Rates**

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

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

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

*(Specific Plan Rates are set forth in Attachment 1 to Exhibit C)*

## 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 mental health services; (v) rules in OAR Chapter 415 pertaining to the provision of Substance Use Disorders services; (vi) state law establishing requirements for Declaration for Mental Health Treatment in ORS 127.700 through 127.737; and (vii) all other applicable requirements of State civil rights and rehabilitation statutes, rules and regulations. These laws, regulations, executive orders and ordinances are incorporated by reference herein to the extent that they are applicable to this Contract and required by law to be so incorporated. OHA’s performance under this Contract is conditioned upon Contractor's compliance with the provisions of ORS 279B.220, ORS 279B.225, 279B.230, 279B.235 and 279B.270, which are incorporated by reference herein. Contractor shall, to the maximum extent economically feasible in the performance of this Contract, use recycled paper (as defined in ORS 279A.010(1)(gg)), recycled PETE products (as defined in ORS 279A.010(1)(hh)), and other recycled products (as "recycled product" is defined in ORS 279A.010(1)(ii)).
- b. In compliance with the Americans with Disabilities Act, any written material that is generated and provided by Contractor under this Contract to Clients or Members, including Medicaid-Eligible Individuals, shall, at the request of such Clients or Members, be reproduced in alternate formats of communication, to include Braille, large print, audiotape, oral presentation, and electronic format. OHA shall not reimburse Contractor for costs incurred in complying with this provision. Contractor shall cause all Subcontractors under this Contract to comply with the requirements of this provision.
- c. Contractor shall comply with the federal laws as set forth or incorporated, or both, in this Contract and all other federal laws applicable to Contractor's performance under this Contract as they may be adopted, amended or repealed from time to time.

### **3. Independent Contractor**

- a.** Contractor is not an officer, employee, or agent of the State of Oregon as those terms are used in ORS 30.265 or otherwise.
- b.** If Contractor is currently performing work for the State of Oregon or the federal government, Contractor by signature to this Contract, represents and warrants that Contractor's Work to be performed under this Contract creates no potential or actual conflict of interest as defined by ORS Chapter 244 and that no statutes, rules or regulations of the State of Oregon or federal agency for which Contractor currently performs work would prohibit Contractor's Work under this Contract. If compensation under this Contract is to be charged against federal funds, Contractor certifies that it is not currently employed by the federal government.
- c.** Contractor is responsible for all federal and State taxes applicable to compensation paid to Contractor under this Contract and, unless Contractor is subject to backup withholding, OHA will not withhold from such compensation any amounts to cover Contractor's federal or State tax obligations. Contractor is not eligible for any social security, unemployment insurance or workers' compensation benefits from compensation paid to Contractor under this Contract, except as a self-employed individual.
- d.** Contractor shall perform all Work as an Independent Contractor. OHA reserves the right (i) to determine and modify the delivery schedule for the Work and (ii) to evaluate the quality of the Work Product; however, OHA may not and will not control the means or manner of Contractor's performance. Contractor is responsible for determining the appropriate means and manner of performing the Work.

### **4. Representations and Warranties**

- a.** Contractor's Representations and Warranties. Contractor represents and warrants to OHA that:
  - (1)** Contractor has the power and authority to enter into and perform this Contract;
  - (2)** This Contract, when executed and delivered, shall be a valid and binding obligation of Contractor enforceable in accordance with its terms;
  - (3)** Contractor has the skill and knowledge possessed by well-informed members of its industry, trade or profession and Contractor will apply that skill and knowledge with care and diligence to perform the Work in a professional manner and in accordance with standards prevalent in Contractor's industry, trade or profession;
  - (4)** Contractor shall, at all times during the term of this Contract, be qualified, professionally competent, and duly licensed to perform the Work; and
  - (5)** Contractor prepared its application related to this Contract, if any, independently from all other Contractors, and without collusion, Fraud, or other dishonesty.
- b.** Warranties Cumulative. The warranties set forth in this section are in addition to, and not in lieu of, any other warranties provided.

### **5. (Reserved)**

### **6. Funds Available and Authorized; Payments**

- a.** Contractor shall not be compensated for Work performed under this Contract by any other agency or department of the State of Oregon or the federal government. OHA certifies that it has sufficient funds currently authorized for expenditure to finance costs of this Contract within OHA's current biennial appropriation or limitation. Contractor understands and agrees that

OHA's payment for Work performed is contingent on OHA receiving appropriations, limitations, allotments, or other expenditure authority sufficient to allow OHA, in the exercise of its reasonable discretion, to continue to make payments under this Contract.

- b. Payment Method.** Payments under this Contract will be made by Electronic Funds Transfer (EFT), unless otherwise mutually agreed. Upon request, Contractor shall provide its taxpayer identification number (TIN) 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 the Contractor elects to designate a different financial institution for the receipt of any payment made using EFT procedures, the Contractor shall provide the changed information or designation to OHA on an OHA-approved form. OHA is not required to make any payment under this Contract until receipt of the correct EFT designation and payment information from the Contractor.

## 7. Recovery of Overpayments

**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, OHA MAY PURSUE A RECOVERY, FOLLOWING THE PROCEDURES IN EXHIBIT C SECTION 5 (SETTLEMENT OF ACCOUNTS). FOLLOWING EXHAUSTION OF THE ADMINISTRATIVE PROCEDURES IN EXHIBIT C, SECTION 5, CONTRACTOR HEREBY REASSIGNS TO OHA ANY RIGHT CONTRACTOR MAY HAVE TO RECEIVE SUCH PAYMENTS. OHA RESERVES ITS RIGHT TO PURSUE ANY OR ALL OF THE REMEDIES AVAILABLE TO IT UNDER THIS CONTRACT AND AT LAW OR IN EQUITY INCLUDING OHA'S RIGHT TO SETOFF OR ANY OTHER CIVIL REMEDY.**

## 8. Indemnity

- a. GENERAL INDEMNITY. CONTRACTOR SHALL DEFEND, SAVE, HOLD HARMLESS, AND INDEMNIFY THE STATE OF OREGON AND OHA AND THEIR OFFICERS, EMPLOYEES AND AGENTS FROM AND AGAINST ALL CLAIMS, SUITS, ACTIONS, LOSSES, DAMAGES, LIABILITIES, COSTS AND EXPENSES OF ANY NATURE WHATSOEVER (INCLUDING REASONABLE ATTORNEYS' FEES AND EXPENSES AT TRIAL, ON APPEAL AND IN CONNECTION WITH ANY PETITION FOR REVIEW) RESULTING FROM, ARISING OUT OF, OR RELATING TO THE ACTIVITIES OF CONTRACTOR OR ITS OFFICERS, EMPLOYEES, SUBCONTRACTORS, OR AGENTS UNDER THIS CONTRACT.**
- b. CONTROL OF DEFENSE AND SETTLEMENT. CONTRACTOR SHALL HAVE CONTROL OF THE DEFENSE AND SETTLEMENT OF ANY CLAIM THAT IS SUBJECT TO THIS SECTION a., ABOVE; 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 FROM THE ATTORNEY GENERAL, IN A FORM AND MANNER DETERMINED APPROPRIATE BY THE ATTORNEY GENERAL, AUTHORITY TO ACT AS LEGAL COUNSEL FOR THE STATE OF OREGON; NOR SHALL CONTRACTOR SETTLE ANY CLAIM ON BEHALF OF THE STATE OF OREGON WITHOUT THE APPROVAL OF THE ATTORNEY GENERAL. THE STATE OF OREGON MAY, AT ITS ELECTION AND EXPENSE, ASSUME ITS OWN DEFENSE AND SETTLEMENT IN THE EVENT THAT THE STATE OF OREGON DETERMINES THAT CONTRACTOR IS PROHIBITED FROM DEFENDING THE STATE OF OREGON, OR IS NOT ADEQUATELY DEFENDING THE STATE OF OREGON'S INTERESTS, OR THAT AN IMPORTANT**

**GOVERNMENTAL PRINCIPLE IS AT ISSUE AND THE STATE OF OREGON DESIRES TO ASSUME ITS OWN DEFENSE.**

- c. TO THE EXTENT PERMITTED BY ARTICLE XI, SECTION 7 OF THE OREGON CONSTITUTION AND BY OREGON TORT CLAIMS ACT, THE STATE OF OREGON SHALL INDEMNIFY, WITHIN THE LIMITS OF THE TORT CLAIMS ACT, CONTRACTOR AGAINST LIABILITY FOR DAMAGE TO LIFE OR PROPERTY ARISING FROM THE STATE'S ACTIVITY UNDER THIS CONTRACT, PROVIDED THE STATE SHALL NOT BE REQUIRED TO INDEMNIFY CONTRACTOR FOR ANY SUCH LIABILITY ARISING OUT OF THE WRONGFUL ACTS OF EMPLOYEES, SUBCONTRACTORS OR AGENTS OF CONTRACTOR.**
- d. THE OBLIGATIONS OF THIS SECTION 9 ARE SUBJECT TO THE LIMITATIONS IN SECTION 11 OF THIS EXHIBIT.**

**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 14 days after OHA's notice or such longer period as OHA may specify in such notice; or
- (3)** Contractor commits any material breach or default of any covenant, warranty, obligation or agreement under this Contract, fails to perform the Work under this Contract within the time specified herein or any extension thereof, or so fails to pursue the Work as to endanger Contractor's performance under this Contract in accordance with its terms, and such breach, default or failure is not cured within 14 days after OHA's notice, or such longer period as OHA may specify in such notice; or
- (4)** Contractor knowingly has a director, officer, partner or person with beneficial ownership of 5% or more of Contractor's equity or has an employment, consulting or other Subcontractor agreement for the provision of items and services that are significant and material to Contractor's obligations under this Contract as specified in 42 CFR 438.610, concerning whom:
  - (a)** Any license or certificate required by law or regulation to be held by Contractor or Subcontractor to provide services required by this Contract is for any reason denied, revoked or not renewed; or
  - (b)** Is suspended, debarred or otherwise excluded from participating in procurement activities under Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued pursuant to Executive Order No. 12549 or under guidelines implementing such order; or
  - (c)** Is suspended or terminated from the Medical Assistance Program or excluded from participation in the Medicare program; or
  - (d)** Is convicted of a felony or misdemeanor related to a crime or violation of Title XVIII, XIX, or XX of the Social Security Act or related laws (or entered a plea of nolo contendere).

- (5) If OHA determines that health or welfare of Members is in jeopardy if this Contract continues; or
  - (6) Contractor fails to enter into an amendment described in Exhibit D, Paragraph 19b., as necessary for the amendment to go into effect on its proposed effective date.
- b. OHA’s Remedies for Contractor’s Default.** In the event Contractor is in default under Section 10.a., above, OHA may, at its option, pursue any or all of the remedies available to it under this Contract and at law or in equity, including, but not limited to:
- (1) Termination of this Contract under Section 10.e.(2) below;
  - (2) Withholding all monies due for Work and Work Products that Contractor has failed to deliver within any scheduled completion dates or has performed inadequately or defectively;
  - (3) Sanctions under Exhibit D, Section 33 through 36 of this Contract;
  - (4) Initiation of an action or proceeding for damages, specific performance, declaratory or injunctive relief; and
  - (5) Exercise of its right of recovery of overpayments under Section 7 of this Exhibit D or setoff or both.

These remedies are cumulative to the extent the remedies are not inconsistent, and OHA may pursue any remedy or remedies singly, collectively, successively or in any order whatsoever. If a court determines that Contractor was not in default under Section 10.a. above, then Contractor shall be entitled to a claim for any unpaid CCO Payments as identified in Exhibit C, less previous amounts paid and any claim(s) that OHA has against Contractor.

- c. Default by OHA.** OHA shall be in default under this Contract if:
- (1) OHA fails to pay Contractor any amount pursuant to the terms of this Contract, net of any reduction for overpayment or other offset, and OHA fails to cure such failure within 15 calendar days after delivery of Contractor’s notice of such failure to pay or such longer period as Contractor may specify in such notice; or
  - (2) OHA commits any material breach or default of any covenant, warranty, or obligation under this Contract, and such breach or default is not cured within 30 days after Contractor’s notice or such longer period as Contractor may specify in such notice.

Any notice of default by Contractor must identify, with specificity, the term or terms of this Contract allegedly breached.

- d. Contractor’s Remedies for OHA’s Default.** In the event OHA terminates this Contract under Section 10.e.(1) below, or in the event OHA is in default under Section 10.c. above and whether or not Contractor elects to exercise its right to terminate this Contract under Section 10.e.(3) below, Contractor’s sole remedy shall be a Claim for any unpaid CCO Payments or case rate or supplemental payments as identified in Exhibit C less previous amounts paid and any claim(s) that OHA has against Contractor. In no event shall OHA be liable to Contractor for any expenses related to termination of this Contract or for anticipated profits. If previous amounts paid to Contractor exceed the amount due to Contractor under this Section 10.d. Contractor shall immediately pay any excess to OHA upon written demand. If Contractor does not immediately pay the excess, OHA may recover the overpayments in accordance with Section 7. “Recovery of Overpayments” above, and may pursue any other remedy that may be available to it.

**e. Termination**

- (1) OHA’s Right to Terminate at its Discretion.** At its sole discretion, OHA may terminate this Contract:
  - (a)** Without cause upon 120 calendar days’ prior written notice by OHA to Contractor; or
  - (b)** Immediately upon written notice if OHA fails to receive funding, appropriations, limitations, allotments or other expenditure authority at levels sufficient to allow OHA, in the exercise of its reasonable discretion, to continue to make payments under this Contract; or
  - (c)** Immediately upon written 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)** Immediately, and notwithstanding any claim Contractor may have under Section 15, “Force Majeure”, upon written notice to Contractor if there is a threat to the health, safety or welfare of any Client, including any Medicaid eligible individual, under its 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 Section 10.e.(3), OHA shall issue notice to Contractor that OHA is terminating this Contract upon the occurrence of any of the following events:
  - (a)** Contractor is in default under Section 10.a.(1) because 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
  - (b)** Contractor is in default under Section 10.a.(2) because Contractor no longer holds a license or certificate that is required for it to perform Work under the Contract and Contractor has not obtained such license or certificate; or
  - (c)** Contractor is in default under Section 10.a.(3) because Contractor commits any material breach or default of any covenant, warranty, obligation or agreement under this Contract, fails to perform the Work under this Contract within the time specified herein or any extension thereof, or so fails to pursue the Work as to endanger Contractor's performance under this Contract in accordance with its terms.
  - (d)** Contractor has failed to carry out the substantive terms of its Contract or meet the applicable requirements of 1932, 1903(m) or 1905(t) of the Social Security Act.
- (3) Before terminating this Contract under Section 10.e.(1) or (2), OHA will:**
  - (a)** Provide Contractor an opportunity to appeal the notice of intent to terminate pursuant to OAR 410-120-1560 and 410-120-1580. In the event that no appeal process is available to Contractor under OAR 410-120-1560, then the Contract shall be terminated in accordance with the termination notice. Where termination is based on failure to comply with a Corrective Action and Contractor has had an Administrative Review on issues substantially similar to the basis for the

- termination decision, such Administrative Review is deemed to satisfy any requirement for a pre-termination hearing; and
- (b) After the hearing or Administrative Review, give Contractor written notice of the decision affirming or reversing the proposed termination of this Contract and, for an affirming decision, the effective date of the termination; and
  - (c) After a decision affirming termination, give Members notice of the termination and information on their options for receiving Medicaid services following the effective date of the termination, consistent with 42 CFR 438.10; and
  - (d) After OHA notifies Contractor that it intends to terminate its Contract under Section 10.e.(1) or (2), 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 if OHA is in default under Section 10.c. and fails to cure such default within the time specified therein.
- (5) Contractor’s Right to Terminate at its Discretion. No later than 134 calendar days prior to the end of a Benefit Period, other than a Benefit Period at the end of which this Contract will expire, OHA shall provide to Contractor notice of the proposed changes to the terms and conditions of the Contract, as will be submitted by OHA to CMS for approval, for the next Benefit Period. At its sole discretion, Contractor may terminate this Contract without cause by written notice to OHA not later than 120 calendar days prior to the date of any Renewal Contract, for termination effective at the Renewal date. A refusal by Contractor to enter into a Renewal Contract terminates this Contract, whether or not Contractor provided the notice described in the previous sentence.
- (6) OHA may require the Contract to remain in force into the next Benefit Period and be amended as proposed by OHA until 90 calendar days after the Contractor has, in accordance with criteria prescribed by OHA:
- (a) Notified each of its Members and contracted Providers of the termination of the Contract;
  - (b) Provided to OHA a plan to transition its Members to another Contractor; and
  - (c) Provided to OHA a plan for closing out its business under this Contract.
- (7) OHA may waive compliance with the deadlines in subsections (5) and (6) of this section if OHA finds that the waiver of the deadlines is consistent with the effective and efficient administration of the Medicaid program and the protection of Members. If Contractor does not execute a Renewal Contract or intends to not Renew, but fails to provide notice of non-Renewal to OHA 120 calendar days prior to the date of any Renewal Contract, OHA may extend this Contract at its discretion for the period of time OHA considers necessary to accomplish the termination planning described in this Subsection e.
- (8) After receipt of the Contractor’s notification of intent not to Renew, or upon an extension of this Contract as described in the previous sentence, OHA will issue written notice to the Contractor specifying the effective date of termination, Contractor’s operational and reporting requirements, and timelines for submission of deliverables.

- (9)** Mutual Termination. 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 terminate automatically under the condition described in Exhibit C, Section 10.
- (11)** The party initiating the termination shall render written notice of termination to the other party by certified mail, return receipt requested, or in person with proof of delivery. The notice of termination 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.
- (12)** After providing or receiving notice of termination, or at least 120 days before expiration of this Contract, Contractor shall:

  - (a)** Submit to OHA a Transition Plan detailing how Contractor will fulfill its continuing obligations under this Contract and identifying an individual (with contract information) as Contractor’s transition coordinator. The Transition Plan is subject to approval by OHA. Contractor shall make revisions to the plan as necessary in order to obtain approval by OHA. Failure to submit a Transition Plan and obtain written approval of the Transition Plan by OHA may result in OHA extending the termination date by the amount of time necessary in order for OHA to approve the Transition Plan submitted by the Contractor. The Transition Plan shall include the prioritization of high-needs Members for care coordination and any other Members requiring high level coordination.
  - (b)** Submit reports to OHA every thirty (30) calendar days detailing the Contractor’s progress in carrying out the Transition Plan. The Contractor, shall submit a final report to OHA describing how the Contractor has fulfilled all its obligations under the Transition Plan including resolution of any outstanding responsibilities.
  - (c)** Maintain adequate staffing to perform all functions specified in Contract.
  - (d)** Promptly supply all information requested by OHA for reimbursement of any claims outstanding at the time of termination.
  - (e)** Promptly make available any signed provider agreements requested by OHA.
  - (f)** Cooperate with OHA to arrange for orderly and timely transfer of Members from coverage under this Contract to coverage under new arrangements authorized by OHA. Such actions of cooperation shall include, but are not limited to Contractor:

    - (1)** Forwarding of all records related to Members, including high-needs care coordination.
    - (2)** Facilitating and scheduling of medically necessary arrangements or appointments for care and services, including arrangements or appointments with Contractor’s network providers for dates of service after the Contract termination date.
    - (3)** Identifying chronically ill, high risk, hospitalized, and pregnant Members in their last four (4) weeks of pregnancy.
    - (4)** 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.

- (g) Make available (including as applicable requiring its Providers to make available), to OHA or another health plan to which OHA has assigned the Member, copies of medical, behavioral, oral health and case care management records, Member files, and any other pertinent information, including information maintained by any subcontractor, as OHA deems necessary for effective Care Management of Members. Such records shall be in a usable form and shall be provided at no expense to OHA or the Member, using a file format and dates for transfer specified by OHA. Information required includes but is not limited to:

  - (1) Prior authorizations approved, denied, or in process;
  - (2) Approved Health Related Services;
  - (3) Program exceptions approved;
  - (4) Current hospitalizations;
  - (5) Information on Members in treatment plans/plans of care who will require continuity of care consideration;
  - (6) Any other information or records deemed necessary by OHA to facilitate the transition of care.
- (h) Arrange for the retention, preservation, and availability of all records under this Contract, including, but not limited to those records related to Member grievance and appeal records, litigation, base data, medical loss ratio data, financial reports, claims settlement information, as required by Contract, State and Federal law.
- (13) Expiration of this Contract is deemed to be a termination of this Contract, without regard to whether OHA and Contractor enter into a successor contract, except that:

  - (a) OHA need furnish no notice of termination for a termination by expiration;
  - (b) If OHA offers Contractor a successor contract to be effective immediately after expiration of this Contract, then OHA will provide to Contractor a notice of the proposed terms and conditions of the Contract, as will be submitted by OHA to CMS for approval, and within 14 calendar days Contractor shall provide OHA with a notice if Contractor does not intend to enter the successor contract. Such notice will not relieve Contractor of any undertakings Contractor has provided to OHA in the procurement for the successor contract;
  - (c) If OHA and Contractor enter into a successor contract that is effective immediately after expiration of this Contract, then OHA may waive those duties of Contractor relating to termination of this Contract that OHA deems unnecessary in view of the successor contract; and
  - (d) Contractor shall perform the actions described in Paragraph 12, 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, 120 days before expiration of this Contract.
- (14) After the effective date of termination of the Contract, Contractor shall:

  - (a) Maintain compliance with all financial requirements set forth in this Contract, including but not limited to restricted reserves and insurance coverage, for eighteen (18) months following the date of termination, or until OHA provides the

- Contractor written release agreeing that all continuing obligations of this Contract have been fulfilled, whichever is earlier.
- (b) Maintain claims processing functions as necessary for a minimum of eighteen (18) months after the date of termination (or longer if it is likely there are additional claims outstanding) in order to complete adjudication of all claims and appeals.
  - (c) Assist OHA with Grievances and Appeals for dates of service prior to the termination date.
  - (d) Submit financial reporting deemed necessary by OHA, including but not limited to:
    - (1) Quarterly and Audited Financial Statements up to the date specified by OHA; and
    - (2) Details related to any existing third-party liability or personal injury lien cases, except to the extent Contractor transfers the cases to OHA's Third Party Liability (TPL) or Personal Injury Lien (PIL) units, as applicable.
- (15) In the event of termination of this Contract, at the end of the term of this Contract if Contractor does not execute a new Contract or upon 120 day notice that Contractor does not intend to Renew this Contract, the following provisions shall apply to ensure continuity of the Work by Contractor. Contractor shall ensure:
- (a) Continuation of services to Members for the period in which a CCO Payment has been made, including inpatient admissions up until discharge;
  - (b) Orderly and reasonable transfer of Member care in progress, whether or not those Members are hospitalized;
  - (c) Timely submission of information, reports and records, including encounter data, required to be provided to OHA during the term of this Contract;
  - (d) Timely payment of Valid Claims for services to Members for dates of service during the term of this Contract; and
  - (e) If Contractor continues to provide services to a Member after the date of termination, OHA is only authorized to pay for services subject to OHA rules on a fee-for-service basis 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.
- (16) Upon termination, OHA shall conduct an accounting of CCO Payments paid or payable and Members enrolled during the month in which termination is effective and shall be accomplished as follows:
- (a) Mid-Month Termination: For a termination of this Contract that occurs during mid-month, the CCO Payments for that month shall be apportioned on a daily basis. Contractor shall be entitled to CCO Payments for the period of time prior to the date of termination and OHA shall be entitled to a refund for the balance of the month.

- (b) Responsibility for CCO Payment/Claims: Contractor is responsible for any and all claims from Subcontractors or other Providers, including Emergency Service Providers, for Covered Services provided prior to the termination date.
  - (c) Notification of Outstanding OHA Claims: Contractor shall promptly notify OHA 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. Contractor shall supply OHA with all information necessary for reimbursement of such claims.
  - (d) 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.
  - (e) Withholding: If this Contract is terminating for any reason and OHA has not approved a Transition Plan by sixty days before the termination date, then OHA may withhold 20% of the Contractor's CCO Payment(s) for the last month of the contract, until OHA has given written approval to the Contractor's Transition Plan.
- (17) After Contractor has satisfied all of its obligations under this Contract, including post-termination obligations and any obligations under any Transition Plan, Contractor shall submit to OHA a written request for release of restricted reserves, stating (under penalty of false claims liability) that all Contractor's obligations under this Contract and any Transition Plan have been satisfied. OHA will thereupon provide a written release of reserves, when OHA is satisfied that Contractor has satisfied all of its obligations under this Contract and any Transition Plan.

## 10. Limitation of Liabilities

- a. **NEITHER PARTY SHALL BE LIABLE FOR INCIDENTAL OR CONSEQUENTIAL DAMAGES ARISING OUT OF OR RELATED TO THIS CONTRACT.**
- b. Contractor shall ensure that OHA is not held liable for any of the following:
  - (1) Payment for Contractor's or any Subcontractor's debts or liabilities in the event of insolvency; or
  - (2) Covered Services authorized or required to be provided under this Contract.

## 11. Insurance

Contractor shall maintain insurance as set forth in Exhibit F, attached hereto.

## 12. Access to Records and Facilities

Contractor shall maintain, and require its Subcontractors and Participating Providers to maintain, all financial records relating to this Contract in accordance with generally accepted accounting principles or National Association of Insurance Commissioners accounting standards. In addition, Contractor shall maintain any other records, books, documents, papers, plans, records of shipments and payments and writings of Contractor, whether in paper, electronic or other form, that are pertinent to this Contract, in such a manner as to clearly document Contractor's performance. All Clinical Records, financial records, other records, books, documents, papers, plans, records of shipments and payments and writings of Contractor whether in paper, electronic or other form, that are pertinent to this Contract, are collectively referred to as "Records." Contractor acknowledges and agrees that OHA, CMS, the

Secretary of State's Office, DHHS, the Office of the Inspector General, the Comptroller General of the United States, the Oregon Department of Justice Medicaid Fraud Control Unit and their duly authorized representatives shall have access to all Records of Contractor and its Subcontractors and Participating Providers to perform examinations and audits and make excerpts and transcripts 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, and equipment where Medicaid-related activities or work is conducted. The right to audit under this section exists for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. Contractor shall retain and keep accessible all Records for the longer of ten years or:

- a. The retention period specified in this Contract for certain kinds of records;
- b. The period as may be required by applicable law, including the records retention schedules set forth in OAR Chapters 410 and 166; or
- c. Until the conclusion of any audit, controversy or litigation arising out of or related to this Contract.

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

### **13. Information Privacy/Security/Access**

If the Work performed under this Contract requires Contractor or, when allowed, its Subcontractor(s), to have access to or use of any OHA computer system or other OHA Information Asset for which OHA imposes security requirements, and OHA grants Contractor access to such OHA Information Assets or Network and Information Systems, Contractor shall comply and require any Subcontractor(s) to which such access has been granted to comply with OAR 943-014-0300 through 943-014-0320, as such rules may be revised from time to time. For purposes of this section, "Information Asset" and "Network and Information System" have the meaning set forth in OAR 943-014-0305, as such rule may be revised from time to time.

### **14. Force Majeure**

- a. Neither OHA nor Contractor shall be held responsible for delay or default caused by riots, acts of God, power outage, fire, civil unrest, labor unrest, natural causes, government fiat, terrorist acts, other acts of political sabotage or war, which is beyond the reasonable control of OHA or Contractor, respectively. Each party shall, however, make all reasonable efforts to remove or eliminate such cause of delay or default and shall, upon the cessation of the cause, diligently pursue performance of its obligations under this Contract. OHA may terminate this Contract upon written notice to Contractor after reasonably determining that the delay or default will likely prevent successful performance of this Contract.
- b. If the rendering of services or benefits under this Contract is delayed or made impractical due to any of the circumstances listed in Section 15.a., above, care may be deferred until after resolution of those circumstances except in the following situations:
  - (1) Care is needed for Emergency Services;
  - (2) Care is needed for Urgent Care Services; or
  - (3) Care is needed where there is a potential for a serious adverse medical consequence if treatment or diagnosis is delayed more than 30 days.

- c. If any of the circumstances listed in Section 15.a., above, disrupts normal execution of Contractor duties under this Contract, Contractor shall notify Members in writing of the situation and direct Members to bring serious health care needs to Contractor's attention.

The foregoing shall not excuse Contractor from performance under this Contract if, and to the extent, the cause of the force majeure event was reasonable 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.

## **15. Foreign Contractor**

If Contractor is not domiciled in or registered to do business in the State of Oregon, Contractor shall promptly provide to the Department of Revenue and the Secretary of State Corporation Division all information required by those agencies relative to this Contract.

## **16. Assignment of Contract, Successors in Interest**

- a. Contractor shall not assign or transfer its interest in this Contract, voluntarily or involuntarily, whether by merger, consolidation, dissolution, operation of law, or in any other manner, without prior written consent of OHA. Any such assignment or transfer, if approved, is subject to such conditions and provisions as OHA may deem necessary, including but not limited to Exhibit B, Part 8, Sections 13 and 14. No approval by OHA of any assignment or transfer of interest shall be deemed to create any obligation of OHA in addition to those set forth in the Contract.
- b. The provisions of this Contract shall be binding upon and inure to the benefit of the parties, their respective successors and permitted assigns.

## **17. Subcontracts**

Contractor shall notify OHA, in writing, of any subcontract(s) for any of the Work required by this Contract other than information submitted in Exhibit G. In addition to any other provisions OHA may require, 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 the Contractor with respect to Sections 1, 2, 3, 4, 13, 14, 17, 18 and 22 of this Exhibit D. OHA's consent to any subcontract shall not relieve Contractor of any of its duties or obligations under this Contract. In addition to the requirements in this section, Contractor shall comply with Exhibit B, Part 8, Section 13.

## **18. No Third Party Beneficiaries**

OHA and Contractor are the only parties to this Contract and are the only parties entitled to enforce its terms. The parties agree that Contractor's performance under this Contract is solely for the benefit of OHA to accomplish its statutory mission. Nothing in this Contract gives, is intended to give, or shall be construed to give or provide any benefit or right, whether directly, indirectly or otherwise, to third persons any greater than the rights and benefits enjoyed by the general public unless such third persons are individually identified by name herein and expressly described as intended beneficiaries of the terms of this Contract.

## **19. Amendments**

- a. OHA may amend this Contract to the extent provided herein, or in RFA 4690, and to the extent permitted by applicable statutes and administrative rules. No amendment, modification or change of terms of this Contract shall bind either party unless in writing and signed by both parties and when required approved by the Department of Justice. Such amendment, modification or change, if made, shall be effective only in the specific instance and for the specific purpose given.

- b.** OHA may provide Contractor with an amendment to this Contract under any of the following circumstances:
- (1)** If OHA is required to amend this Contract due to changes in federal or State statute or regulations, or due to changes in Covered Services and CCO Payments under ORS 414.735, and if failure to amend this Contract to execute those changes in the time and manner proposed in the amendment may place OHA at risk of non-compliance with federal or State statute or regulations or the requirements of the Legislature or Legislative Emergency Board.
  - (2)** To address budgetary constraints, including those arising from changes in funding, appropriations, limitations, allotments, or other expenditure authority limitations provided in Section 6 of this Exhibit D.
  - (3)** If this Contract is amended to reduce or expand the Service Area, reduce or expand the Enrollment limit, or both, and a CCO Payment Rate change is made under Exhibit B, Part 4, Section 11.
  - (4)** To the extent such changes are required to obtain CMS approval of this Contract or the CCO Payment Rates.

OHA will send to Contractor the necessary Contract amendments no later than 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 Exhibit D, Paragraph 10.a(6).

- c.** Per capita rates are actuarially certified annually. Rates will be amended annually along with required language changes, as allowed for in ORS 414.652 (1) and Exhibit C, Section 10.
- d.** Any changes in the CCO Payment Rates under ORS 414.735 shall take effect on the date approved by the Legislative Assembly or the Legislative Emergency Board. 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.

## **20. Waiver**

No waiver or other consent under this Contract shall bind either party unless it is in writing and signed by the party to be bound. Such waiver or consent shall be effective only in the specific instance and for the specific purpose given. The failure of either party to enforce any provision of this Contract shall not constitute a waiver by that party of that or any other provision.

## **21. Severability**

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

## **22. Survival**

**a.** Standard Terms and Conditions

Sections 1, 4, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 17, 19, 22 and 23 of this Exhibit D shall survive Contract expiration or termination, as well as those provisions of this Contract that by their context are meant to survive. Contract expiration or termination shall not extinguish or prejudice OHA's right to enforce this Contract with respect to any default by Contractor that has not been cured.

**b. Special Terms and Conditions**

In addition to any other provisions of this Contract that by their context are meant to survive Contract expiration or termination, the following special terms and conditions survive Contract expiration or termination, for a period of 2 (two) 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 the Contractor's authorized representative, subject to False Claims Act liability;
- (c)** Adjustments to encounter claims in the event Contractor receives payment from a Member's Third Party Liability or Third Party Recovery; and
- (d)** Adjustments to encounter claims in the event Contractor recovers any overpayment from a Provider.

**(2) Financial Reporting**

- (a)** Quarterly financial statements as defined in Exhibit L;
- (b)** Audited annual financial statements as defined in Exhibit L;
- (c)** Submission of details related to ongoing Third Party Liability and Third Party Recovery activities by Contractor or its Subcontractors;
- (d)** Submission of any and all financial information related to the calculation of Contractor's MMLR; and
- (e)** Data related to the calculation of quality and performance metrics.

**(3) Operations**

- (a)** Point of contact for operations while transitioning;
- (b)** Claims processing;
- (c)** Provider and member grievances and appeals; and
- (d)** Implementation of and any necessary modifications to the Transition Plan.

**(4) Corporate Governance**

- (a)** Oversight by governing board and community advisory council;
- (b)** Not initiating voluntary bankruptcy, liquidation, or dissolution;
- (c)** Maintenance of all licenses, certifications, and registrations necessary to do the business of a CCO in Oregon; and
- (d)** Responding to subpoenas, investigations, and governmental inquiries.

**(5) Financial Obligations**

The following requirements survive Contract expiration or termination indefinitely:

- (a)** Reconciliation of risk corridor payments;

- (b) Reconciliation of setoffs;
  - (c) Recoupment of MMLR Rebates;
  - (d) Reconciliation of prescription drug rebates;
  - (e) Recoupment of capitation paid for members deemed ineligible or who were enrolled into an incorrect benefit category; and
  - (f) Recoupment of any identified overpayment.
- (6) Sanctions and Liquidated Damages
- (a) Contract expiration or termination does not limit OHA’s ability to impose a sanction or apply Liquidated Damages.
  - (b) The decision to impose a sanction or apply Liquidated Damages does not prevent OHA from imposing additional sanctions at a later date.

Sanctions imposed on Contractor after Contract expiration or termination will be reported to CMS according to the requirements set out in Exhibit B – Part 8.

**23. Notices**

- a. Except as otherwise expressly provided in this Contract, any notices between the parties hereto or notices to be given hereunder must be given in writing by personal delivery, facsimile, email, express mail, or postal mail. The expenses of delivery must be prepaid. Any such communication or notice is deemed received:
- (1) If given by personal delivery, when actually delivered to the addressee.
  - (2) If delivered by facsimile, on the day the transmitting machine generates a receipt of the successful transmission, if transmission was during normal business hours of the recipient, or on the next Business Day if transmission was outside normal business hours of the recipient. Notwithstanding the foregoing, to be effective against the other party, any notice transmitted by facsimile must be confirmed by telephone notice to the other party at the number listed below.
  - (3) If delivered by email, when the addressee personally acknowledges receipt. An automatically generated message is not an acknowledgment of receipt.
  - (4) If delivered by express mail, on the day of delivery if a Business Day or the otherwise the next Business Day.
  - (5) If delivered by regular mail, five Business Days after the date of mailing.
- b. Notices or other communications to Contractor or OHA must be directed to the address or number set forth below, or to such other addresses or numbers as either party may indicate pursuant to this section. Except as otherwise expressly provided in this Contract, the parties’ contact information is:

OHA: Office of Contracts & Procurement  
DHS/OHA Shared Services  
635 Capitol Street NE Room 350 Salem, Oregon 97301  
Telephone: 503-945-5818  
Facsimile: 503-378-4324

Contractor: See Contract Document, Section IV.B

**24. Construction**

This Contract is the product of extensive negotiations between OHA and Contractor. The provisions of this Contract are to be interpreted and their legal effects determined as a whole. The rule of construction that ambiguities in a written agreement are to be construed against the party preparing or drafting the agreement shall not be applicable to the interpretation of this Contract.

**25. Headings**

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

**26. Merger Clause**

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

**27. 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.

**28. Equal Access**

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

**29. Media Disclosure**

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

**30. Mandatory Reporting**

- a. Contractor shall immediately report any evidence of child abuse, neglect or threat of harm to DHS Child Protective Services or law enforcement officials in full accordance with the mandatory Child Abuse Reporting law (ORS 419B.005 to 419B.045). If law enforcement is notified, the Contractor shall notify the referring caseworker within 24 hours. Contractor shall immediately contact the local DHS Child Protective Services office if questions arise whether an incident meets the definition of child abuse or neglect.
- b. Contractor shall comply, and shall require its Participating Providers to comply, with all protective services, investigation and reporting requirements described in any of the following laws:
  - (1) OAR 407-045-0000 through 407-045-0370 (abuse investigations by the Office of Investigations and Training);
  - (2) ORS 430.735 through 430.765 (persons with mental illness or developmental disabilities);
  - (3) ORS 124.005 to 124.040 (elderly persons and persons with disabilities abuse); and
  - (4) ORS 441.650 to 441.680 (residents of long term care facilities)

## **Exhibit E - Required Federal Terms and Conditions**

Unless exempt under 45 CFR Part 87 for Faith-Based Organizations (Federal Register, July 16, 2004, Volume 69, #136), or other federal provisions, Contractor shall comply and, as indicated, cause all Subcontractors to comply with the following federal requirements to the extent that they are applicable to this Contract, to Contractor, or to the Work, or to any combination of the foregoing. For purposes of this Contract, all references to federal and State laws are references to federal and State laws as they may be amended from time to time.

### **1. Miscellaneous Federal Provisions**

Contractor shall comply and require all Subcontractors to comply with all federal laws, regulations and executive orders applicable to this Contract or to the delivery of Work. Without limiting the generality of the foregoing, Contractor expressly agrees to comply and require all Subcontractors to comply with the following laws, regulations and executive orders to the extent they are applicable to this Contract: (a) Title VI and VII of the Civil Rights Act of 1964, as amended, (b) 45 CFR Part 84 which implements, Title V, Sections 503 and 504 of the Rehabilitation Act of 1973, as amended, (c) the Americans with Disabilities Act of 1990, as amended, (d) Section 1557 of the Patient Protection and Affordable Care Act (ACA), (e) Executive Order 11246, as amended, (f) the Health Insurance Portability and Accountability Act of 1996, as amended, (g) the Age Discrimination in Employment Act of 1967, as amended, and the Age Discrimination Act of 1975, as amended, (h) the Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended, (i) the Mental Health Parity and Addiction Equity Act of 2008, as amended; (j) CMS regulations (including 42 CFR Part 438, subpart K) and guidance regarding mental health parity, including 42 CFR 438.900 et. seq.; (k) all regulations and administrative rules established pursuant to the foregoing laws, (l) all other applicable requirements of federal civil rights and rehabilitation statutes, rules and regulations, and (m) all federal laws requiring reporting of Member abuse. These laws, regulations and executive orders are incorporated by reference herein to the extent that they are applicable to this Contract and required by law to be so incorporated. No federal funds may be used to provide Work in violation of 42 USC. 14402.

### **2. Equal Employment Opportunity**

If this Contract, including amendments, 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 to OHA, United States Department of Health and Human Services and the appropriate Regional Office of the Environmental Protection Agency. Contractor shall include and require all Subcontractors to include in all contracts with Subcontractors receiving more than \$100,000, language requiring the Subcontractor to comply with the federal laws identified in this section.

#### **4. Energy Efficiency**

Contractor shall comply and require all Subcontractors to comply with applicable mandatory standards and policies relating to energy efficiency that are contained in the Oregon energy conservation plan issued in compliance with the Energy Policy and Conservation Act, 42 USC 6201 et seq. (Pub. L. 94-163).

#### **5. Truth in Lobbying**

By signing this Contract, the Contractor certifies, to the best of the Contractor's knowledge and belief that:

- a.** No federal appropriated funds have been paid or will be paid, by or on behalf of Contractor, to any person for influencing or attempting to influence an officer or employee of an agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment or modification of any federal contract, grant, loan or cooperative agreement.
- b.** If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with this federal contract, grant, loan or cooperative agreement, the Contractor shall complete and submit Standard Form LLL, "Disclosure Form to Report Lobbying" in accordance with its instructions.
- c.** The Contractor shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients and Subcontractors shall certify and disclose accordingly.
- d.** This certification is a material representation of fact upon which reliance was placed when this Contract was made or entered into. Submission of this certification is a prerequisite for making or entering into this Contract imposed by Section 1352, Title 31, of the U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.
- e.** No part of any federal funds paid to Contractor under this Contract shall be used other than for normal and recognized executive legislative relationships, for publicity or propaganda purposes, for the preparation, distribution, or use of any kit, pamphlet, booklet, publication, electronic communication, radio, television, or video presentation designed to support or defeat the enactment of legislation before the United States Congress or any State or local legislature itself, or designed to support or defeat any proposed or pending regulation, administrative action, or order issued by the executive branch of any State or local government itself.
- f.** No part of any federal funds paid to Contractor under this Contract shall be used to pay the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or executive order proposed or pending before the United States Congress or any State government, State legislature or local legislature or legislative body, other than for normal and recognized executive-legislative relationships or participation by an agency or officer of a State, local or tribal government in policymaking and administrative processes within the executive branch of that government.

- g.** The prohibitions in subsections (e) and (f) of this section shall include any activity to advocate or promote any proposed, pending or future Federal, State or local tax increase, or any proposed, pending, or future requirement or restriction on any legal consumer product, including its sale or marketing, including but not limited to the advocacy or promotion of gun control.
- h.** No part of any federal funds paid to Contractor under this Contract may be used for any activity that promotes the legalization of any drug or other substance included in schedule I of the schedules of controlled substances established under Section 202 of the Controlled Substances Act except for normal and recognized executive congressional communications. This limitation shall not apply when there is significant medical evidence of a therapeutic advantage to the use of such drug or other substance of that federally sponsored clinical trials are being conducted to determine therapeutic advantage.

## **6. HIPAA Compliance**

The parties acknowledge and agree that each of OHA and the Contractor is a “covered entity” for purposes of privacy and security provisions of the Health Insurance Portability and Accountability Act and its implementing federal regulations (collectively referred to as HIPAA). OHA and Contractor shall comply with HIPAA to the extent that any Work or obligations of OHA arising under this Contract are covered by HIPAA. Contractor shall develop and implement such policies and procedures for maintaining the privacy and security of records and authorizing the use and disclosure of records required to comply with this Contract and with HIPAA. Contractor shall comply and cause all Subcontractors to comply with HIPAA and the following:

- a.** Privacy and Security of Individually Identifiable Health Information. Individually Identifiable Health Information about specific individuals is protected from unauthorized use or disclosure consistent with the requirements of HIPAA. Individually Identifiable Health Information relating to specific individuals may be exchanged between Contractor and OHA for purposes directly related to the provision of services to Members which are funded in whole or in part under this Contract. However, Contractor shall not use or disclose any Individually Identifiable Health Information about specific individuals in a manner that would violate HIPAA Privacy Rules in 45 CFR Parts 160 and 164, OHA Privacy Rules, OAR Chapter 407 Division 014, or OHA Notice of Privacy Practices, if done by OHA. A copy of the most recent OHA Notice of Privacy Practices is posted on the OHA web site at: <https://apps.state.or.us/cf1/FORMS/>, Form number ME2090 Notice of Privacy Practices, or may be obtained from OHA.
- b.** HIPAA Information Security. Contractor shall adopt and employ reasonable administrative and physical safeguards consistent with the Security Rules in 45 CFR Part 164 to ensure that Member Information shall be used by or disclosed only to the extent necessary for the permitted use or disclosure and consistent with applicable State and federal laws and the terms and conditions of this Contract. Security incidents involving Member Information must be immediately reported to DHS’ Privacy Officer.
- c.** Data Transactions Systems. Contractor shall comply with the HIPAA standards for electronic transactions published in 45 CFR Part 162 and the DHS EDT Rules, OAR 410-001-0000 through 410-001-0200. In order for Contractor to exchange electronic data transactions with OHA in connection with claims or encounter data, eligibility or Enrollment information, authorizations or other electronic transaction, Contractor shall execute an EDT Trading Partner Agreement with OHA and shall comply with the OHA EDT Rules.
- d.** Consultation and Testing. If Contractor reasonably believes that the Contractor's or OHA’s data transactions system or other application of HIPAA privacy or security compliance policy may result in a violation of HIPAA requirements, Contractor shall promptly consult the OHA HIPAA

officer. Contractor or OHA may initiate a request for testing of HIPAA transaction requirements, subject to available resources and OHA testing schedule.

## **7. Resource Conservation and Recovery**

Contractor shall comply and require all Subcontractors to comply with all mandatory standards and policies that relate to resource conservation and recovery pursuant to the Resource Conservation and Recovery Act (codified at 42 U.S.C. 6901 et seq.). Section 6002 of that Act (codified at 42 U.S.C. 6962) requires that preference be given in procurement programs to the purchase of specific products containing recycled materials identified in guidelines developed by the Environmental Protection Agency. Current guidelines are set forth in 40 CFR Part 247.

## **8. Audits**

- a.** Contractor shall comply, and require all subcontractors to comply, with applicable audit requirements and responsibilities set forth in this Contract and applicable state or federal law.
- b.** If Contractor expends \$750,000 or more in federal funds (from all sources) in a federal fiscal year, Contractor shall have a single organization-wide audit conducted in accordance with the provisions of 2 CFR Subtitle B with guidance at 2 CFR Part 200. Copies of all audits must be submitted to OHA within 30 days of completion. If Contractor expends less than \$750,000 in a federal fiscal year, Contractor is exempt from Federal audit requirements for that year. Records must be available as provided in Exhibit B, "Records Maintenance, Access".

## **9. Debarment and Suspension**

Contractor shall, in accordance with 42 CFR 438.808(b), not permit any person or entity to be a Subcontractor if the person or entity is listed on the non-procurement portion of the General Service Administration's "List of Parties Excluded from Federal Procurement or Nonprocurement Programs" in accordance with Executive Orders No. 12549 and No. 12689, "Debarment and Suspension". (See 2 CFR Part 180). This list contains the names of parties debarred, suspended, or otherwise excluded by agencies, and contractors declared ineligible under statutory authority other than Executive Order No. 12549. Subcontractors with awards that exceed the simplified acquisition threshold shall provide the required certification regarding their exclusion status and that of their principals prior to award.

Contractor shall ensure that no amounts are paid to a Provider that could be excluded from participation in Medicare or Medicaid for any of the following reasons:

- a.** The Provider is controlled 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 the Contractor from knowingly having a person with ownership of 5% or more of the Contractor's equity if such person is (or is affiliated with a person or entity that is) debarred, suspended, or excluded from participation in federal healthcare programs.

- e. If OHA learns that Contractor has a prohibited relationship with a person or entity that is debarred, suspended, or excluded from participation in federal healthcare programs, OHA:
  - (1) Must notify DHHS of Contractor’s noncompliance;
  - (2) May continue an existing agreement with the Contractor unless DHHS directs otherwise; and
  - (3) May not renew or extend the existing contract with the Contractor unless DHHS provides to the State a written statement describing compelling reasons that exist for renewing or extending the Contract, consistent with 42 CFR 438.610.

**10. Pro-Children Act**

Contractor shall comply and require all Subcontractors to comply with the Pro-Children Act of 1994 (codified at 20 U.S.C. Section 6081 et seq.).

**11. Additional Medicaid and CHIP**

Contractor shall comply with all applicable federal and State laws and regulations pertaining to the provision of OHP Services under the Medicaid Act, Title XIX, 42 USC Section 1396 et seq., and CHIP benefits established by Title XXI of the Social Security Act, including without limitation:

- a. Keep such records as are necessary to fully disclose the extent of the services provided to individuals receiving OHP assistance and shall furnish such information to any State or federal agency responsible for administering the OHP program regarding any payments claimed by such person or institution for providing OHP Services as the State or federal agency may from time to time request. 42 USC Section 1396a(a)(27); 42 CFR § 431.107(b)(1) & (2); and 42 CFR §457.950(a)(3).
- b. Comply with all disclosure requirements of 42 CFR §1002.3(a); 42 CFR §455 Subpart (B); and 42 CFR 457.900(a)(2).
- c. Certify when submitting any claim for the provision of OHP Services that the information submitted is true, accurate and complete. Contractor shall acknowledge Contractor's understanding that payment of the claim will be from federal and State funds and that any falsification or concealment of a material fact may be prosecuted under federal and State laws.

**12. Agency-based Voter Registration**

If applicable, Contractor shall comply with the Agency-based Voter Registration sections of the National Voter Registration Act of 1993 that require voter registration opportunities be offered where an individual may apply for or receive an application for public assistance.

**13. Clinical Laboratory Improvements**

Contractor shall and shall ensure that any Laboratories used by Contractor shall comply with the Clinical Laboratory Improvement Amendments (CLIA 1988), 42 CFR Part 493 Laboratory Requirements and ORS 438 (Clinical Laboratories, which require that all laboratory testing sites providing services under this Contract shall have either a Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number. Those Laboratories with certificates of waiver will provide only the eight types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.

#### **14. Advance Directives**

Contractor shall comply with 42 CFR Part 422.128 for maintaining written policies and procedures for Advance Directives. This includes compliance with 42 CFR 489, Subpart I “Advance Directives” and OAR 410-120-1380, which establishes, among other requirements the requirements for compliance with Section 4751 of the Omnibus Budget Reconciliation Act of 1991 (OBRA) and ORS 127.649, Patient Self-Determination Act. Contractor shall maintain written policies and procedures concerning Advance Directives with respect to all adult Members receiving medical care by Contractor. Contractor shall provide adult Members with written information on Advance Directive policies and include a description of Oregon law. The written information provided by Contractor must reflect changes in Oregon law as soon as possible, but no later than 90 days after the effective date of any change to Oregon law. Contractor must also provide written information to adult Members with respect to the following:

- a. Their rights under Oregon law; and
- b. Contractor’s policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of Advance Directives as a matter of conscience.
- c. The Contractor must inform Members that complaints concerning noncompliance with the Advance Directive requirements may be filed with OHA.

Contractor is prohibited from conditioning the provision of care or otherwise discriminating against a Member based on whether or not the individual has executed an advance directive per 42 CFR §438.3(j); 42 CFR §422.128; or 42 CFR §489.102(a)(3).

#### **15. Practitioner Incentive Plans (PIP)**

Contractor may operate a Practitioner Incentive Plan only if no specific payment is made directly or indirectly under the plan to a Provider as inducement to reduce or limit Medically Appropriate Covered Services provided to a Member. Contractor shall comply with all requirements of Exhibit H, Practitioner Incentive Plan Regulation Guidance, to ensure compliance with Sections 4204 (a) and 4731 of the Omnibus Budget Reconciliation Act of 1990 that concern Practitioner Incentive Plans.

#### **16. Risk HMO**

If Contractor is a Risk HMO and is sanctioned 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 appropriate policies and procedures to avoid actual or potential conflict of interest involving Members, DHS or OHA employees, and sub-contractors. These policies and procedures shall include safeguards:
  - (1) against the Contractor’s disclosure of applications, bids, proposal information, or source selection information; and
  - (2) requiring the Contractor to:
    - (a) promptly report any contact with an Contractor, bidder or offeror in writing to OHA; and
    - (b) reject the possibility of possible employment; or disqualify itself from further personal and substantial participation in the procurement if Contractor contacts or is contacted by a person who is an Contractor, bidder or offeror in a procurement involving federal funds regarding possible employment for the Contractor.
- g. The provisions of this section on Conflict of Interest are intended to be construed to assure the integrity of the procurement and administration of this Contract. For purposes of this Section:
  - (1) “Contract” includes any similar contract between Contractor and OHA for a previous term.
  - (2) Contractor shall apply the definitions in the State Public Ethics Law, ORS 244.020, for “actual conflict of interest”, “potential conflict of interest”, “relative” and “member 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 the Contractor; any officers, directors, partners, agents and employees of such person; and all others acting or claiming to act on their behalf or in concert with them.
  - (4) “Participates” means actions of a DHS or OHA employee, through decision, approval, disapproval, recommendation, the rendering of advice, investigation or otherwise in connection with the Contract.
  - (5) “Personally and substantially” has the same meaning as “personal and substantial” as set forth in 5 CFR 2635.402(b)(4).

## **18. Non-Discrimination**

Contractor shall comply, and require its Subcontractors to comply, with all federal and State laws and regulations including Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972 (regarding education programs and activities) the Age Discrimination Act of 1975, the Rehabilitation Act of 1973, the Americans with Disabilities Act (ADA) of 1990, and all amendments to those acts and all regulations promulgated thereunder. Contractor shall also comply with all applicable requirements of State civil rights and rehabilitation statutes and rules.

## **19. OASIS**

To the extent applicable, Contractor shall comply with, and shall require Subcontractors to comply with, the Outcome and Assessment Information Set (OASIS) reporting requirements and patient notice requirements for skilled services provided by Home Health Agencies, pursuant to CMS requirements published in 42 CFR 484.20, and such subsequent regulations as CMS may issue in relation to the OASIS program.

## **20. Patient Rights Condition of Participation**

To the extent applicable, Contractor shall comply with, and shall require Subcontractors to comply with, the Patient Rights Condition of Participation (COP) that Hospitals must meet to continue participation in the Medicaid program, pursuant to 42 CFR Part 482. For purposes of this Contract, Hospitals include short-term, psychiatric, rehabilitation, long-term, and children's hospitals.

## **21. Federal Grant Requirements**

The federal Medicaid rules establish that OHA is a recipient of federal financial assistance, and therefore is subject to federal grant requirements pursuant to 42 CFR 430.2(b). To the extent applicable to Contractor or to the extent OHA requires Contractor to supply information or comply with procedures to permit OHA to satisfy its obligations federal grant obligations or both, Contractor must comply with the following parts of 45 CFR:

- a. Part 74, including Appendix A (uniform federal grant administration requirements);
- b. Part 92 (uniform administrative requirements for grants to state, local and tribal governments);
- c. Part 80 (nondiscrimination under Title VI of the Civil Rights Act);
- d. Part 84 (nondiscrimination on the basis of handicap);
- e. Part 91 (nondiscrimination on the basis of age);
- f. Part 95 (Medicaid and CHIP federal grant administration requirements); and
- g. Contractor shall not expend, and Contractor shall include a provision in any Subcontract that its Subcontractor shall not expend, any of the funds paid under this Contract for roads, bridges, stadiums, or any other item or service not covered under the OHP.

## **22. Mental Health Parity**

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

- a. If Contractor does not include an aggregate lifetime or annual dollar limit on any medical/surgical benefits or includes an aggregate lifetime or annual dollar limit that applies to less than one-third of all medical/surgical benefits provided to enrollees, it may not impose an aggregate lifetime or annual dollar limit, respectively, on mental health or substance use disorder benefits;

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

## Exhibit F – Insurance Requirements

**Required Insurance:** Contractor shall obtain at Contractor’s expense the insurance specified in this Exhibit F, prior to performing under this Contract, and shall maintain it in full force and at its own expense throughout the duration of this Contract. Contractor shall obtain the following insurance from insurance companies or entities that are authorized to transact the business of insurance and issue coverage in the State of Oregon and that are acceptable to OHA.

- 1. Workers’ Compensation:** All employers, including Contractor, that employ subject workers, as defined in ORS 656.027, shall comply with ORS 656.017, and shall provide worker’s compensation insurance coverage for those workers, unless they meet the requirement for an exemption under ORS 656.126(2). If Contractor is a subject employer, as defined in ORS 656.023, Contractor shall obtain employers’ liability insurance coverage. Contractor shall require and ensure that each of its Subcontractors complies with these requirements.
- 2. Professional Liability:** Covers any damages caused by an error, omission or any negligent acts related to the services to be provided under this Contract. This insurance shall include claims of negligent Provider selection, direct corporate professional liability, wrongful denial of treatment, and breach of privacy. Contractor shall provide proof of insurance with not less than the following limits:

Per occurrence limit for any single Claimant of not less than \$2,000,000, and

Per occurrence limit for multiple Claimants of not less than \$4,000,000.

- 3. Commercial General Liability:** Covers bodily injury, death and property damage in a form and with coverages that are satisfactory to the State. This insurance shall include personal injury liability, products and completed operations. Coverage shall be written on an occurrence basis. Contractor shall provide proof of insurance with not less than the following limits:

### **Bodily Injury/Death**

A combined single limit per occurrence of not less than \$2,000,000, and

An aggregate limit for all claims of not less than \$4,000,000.

AND

### **Property Damage:**

A combined single limit per occurrence of not less than \$200,000, and

An aggregate limit for all claims of not less than \$600,000.

- 4. Automobile Liability:** Insurance covering all owned, non-owned, or hired vehicles. This coverage may be written in combination with the Commercial General Liability Insurance (with separate limits for “Commercial General Liability” and “Automobile Liability”). Contractor shall provide proof of insurance with no less than the following limits:

### **Bodily Injury/Death**

A combined single limit per occurrence of not less than \$2,000,000, and

An aggregate limit for all claims of not less than \$4,000,000.

AND

### **Property Damage:**

A combined single limit per occurrence of not less than \$200,000, and

An aggregate limit for all claims of not less than \$600,000.

From July 1, 2016 and every year thereafter, the coverage limitations set forth herein shall be adjusted to comply with the limits determined by the State Court Administrator pursuant to ORS 30.271(4).

5. **Additional Insured:** The Commercial General Liability insurance and Automobile Liability insurance required under this Contract shall include the State of Oregon, its officers, employees and agents as Additional Insureds but only with respect to Contractor's activities to be performed under this Contract. Coverage shall be primary and non-contributory with any other insurance and self-insurance.
6. **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 60 days prior written notice from Contractor or its insurer(s) to OHA. Any failure to comply with this clause constitutes a material breach of Contract and is grounds for immediate termination of this Contract by OHA.
7. **Proof of Insurance:** Contractor shall provide to OHA information requested in Part VII “Contractor Data and Certification” of the Contract Document, for all required insurance before delivering any goods and performing any services required under this Contract. Contractor shall pay for all deductibles, self-insured retentions, and self-insurance, if any.
8. **“Tail” Coverage:** If any of the required liability insurance is on a “claims made” basis, Contractor shall either maintain either “tail” coverage or continuous “claims made” liability coverage, provided the effective date of the continuous “claims made” coverage is on or before the effective date 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) The expiration of all warranty periods provided under this Contract. Notwithstanding the foregoing 24-month requirement, if Contractor elects to maintain “tail” coverage and if the maximum time period “tail” coverage reasonably available in the marketplace is less than the 24-month period described above, then Contractor shall maintain “tail” coverage for the maximum time period that “tail” coverage is reasonably available in the marketplace for the coverage required under this Contract. Contractor shall provide to OHA, upon OHA’s request, certification of the coverage required under this Section 8.
9. **Self-insurance:** Contractor may fulfill one or more of its insurance obligations herein through a program of self-insurance, provided that Contractor’s self-insurance program complies with all applicable laws, provides coverage equivalent in both type and level to that required in this Exhibit F, and is reasonably acceptable to OHA. Notwithstanding Section 7 of this Exhibit F, Contractor shall furnish 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, Cooperative Agreements, and Hospital Adequacy**

### **1. Delivery System Network (DSN) Reports**

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

Contractor shall maintain and monitor a Participating Provider Panel that is supported with written agreements. Contractor shall ensure to encompass the scope of network adequacy standards established in accordance with paragraphs (b)(1) and (2) of 42 CFR 438.206 must provide for member access in all geographic areas covered by the managed care program or, if applicable, the contract between the State and CCO. 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. Contractor shall ensure access to integrated and coordinated care as outlined in OAR 410-141-3160, maintain a Provider Panel of sufficient capacity and expertise to provide adequate, timely and Medically Appropriate access to members and ensure access to a provider network that meets time and distance standards in OAR 410-141-3220 and the time to appointments timeframes in OAR 410-141-3220.

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

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

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

- a. Travel time and distance to providers;
- b. Wait time to appointment for primary care, specialty care, oral health, and behavioral health services;
- c. Provider to enrollee ratios;
- d. Percentage of contracted providers accepting new OHP members;
- e. Hours of operation;
- f. Call center performance and accessibility;
- g. Availability of language services and accommodations for physical accessibility; and
- h. Any other measure defined in OAR 410-141-3220.

### **2. DSN Provider Report**

- a. Pursuant to 42 CFR 438.68 “Network adequacy standards” and 457.1230 Access standards,” Contractor shall report to OHA annually, in a form provided by OHA, (a) how Contractor monitors and ensures that all Covered Services are available and accessible to Members, pursuant to 42 CFR 438.206 and 457.1230 CHIP, and (b) that the Contractor maintains adequate Provider capacity and meets access standards defined in contract or in OAR 410-141-3220. When developing its provider network, Contractor agrees to contract with a sufficient number of providers to ensure that at minimum 90% of its enrollees do not exceed routine travel time or

- distance standards established in OAR 410-141-3220 when using a means of transportation ordinarily used by enrollees.
- b.** Contractor agrees to develop a system and methodology for monitoring and evaluating member access including, but not limited to, the availability of network providers within time and distance standards, adherence to standards for wait time to appointment for primary care, specialty care, and behavioral health services, and sufficiency of language services and physical accessibility. Contractor agrees to promptly and fully remedy any provider network deficiencies identified through the course of self-assessment, OHA monitoring, or EQRO review.
  - c.** The accuracy of data submitted in the DSN Provider Report will be periodically validated against available sources. If data for more than 10 percent of providers is incorrect for individual data elements, OHA may require Contractor to implement a Corrective Action Plan, or issue penalties or sanctions associated with failure to maintain an adequate provider network.
  - d.** If any activities have been subcontracted or delegated, Contractor must also describe its oversight and monitoring procedures to ensure compliance with the requirements of this Contract.
  - e.** Contractor shall include in the DSN Provider Report a description of:
    - (1)** How contractor identifies and incorporates the needs of linguistically and culturally diverse populations within its community;
    - (2)** Processes used to develop, maintain and monitor an appropriate provider network that is sufficient to provide adequate access to all services covered under this Contract;
    - (3)** Processes used to assess timely access to services including the methodology used to collect and analyze enrollee, provider and staff feedback about the provider network and performance, and, when specific issues are identified, the protocols for correcting them;
    - (4)** How Contractor utilizes Grievance and Appeal data to identify member access issues by geographic area, by provider type, by special needs populations, and by subcontractor or subcontracted activity;
    - (5)** An evaluation of the prior year's report and a description of how previously identified issues have been corrected.
  - f.** Contractor shall also include in the DSN Provider Report a description of current barriers to network adequacy, gaps in the Contractor's provider network, and how it intends to resolve those deficiencies including the following:
    - (1)** The methodology used to identify barriers and network gaps;
    - (2)** Immediate short-term interventions to correct network gaps;
    - (3)** Long-term interventions to fill network gaps and resolve barriers;
    - (4)** Outcome measures for evaluating the efficacy of interventions to fill network gaps and resolve barriers;
    - (5)** Projection of changes in future capacity needs; and
    - (6)** Ongoing activities for network development based on identified gaps and future needs projection;
    - (7)** Contractor's failure to develop, maintain, monitor and ensure access to an adequate provider network may be grounds for OHA to impose penalties, corrective action, or

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

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

### 3. Provider Capacity

- a. Contractor shall ensure sufficient provider capacity for all categories of service and types of service providers necessary to ensure timely and appropriate access to services. Contractor's service providers, whether under contract or subcontract with Contractor, must have agreed to provide the described services or items to its Medicaid and Fully Dual Eligible Members to be included in Contractor's DSN Provider Report. Contractor shall develop its provider network incorporating the priorities from its Community Health Assessment, its Community Health Improvement Plan, and Transformation and Quality Strategy for delivery of integrated and coordinated physical, oral health , mental health, and Substance Use Disorders treatment services and supports.
- b. Contractor shall complete the DSN Provider report and include all the required data elements in the report for both individual Providers and contracted Facilities.
- c. Providers listed in DSN Provider Report shall be categorized by Provider Taxonomy Code. All providers under contract with Contractor or its Subcontractors to provide services to its members must be listed in the DSN Provider Report.

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

- d. Contractor shall identify any providers who have been terminated from the Contractor's provider network, the reason for termination, the number of members impacted by the termination, and any other information listed on the report.
- e. For any Provider that has been terminated for cause, whether that Provider is contracted directly or through Contractor's Subcontractor or delegated entity to provide services, Contractor must notify OHA in writing within 30 days that the Provider is no longer available to its members. Contractor must provide the reason for the termination and indicate how many members are affected by the termination, and whether the termination was the result of issues related to quality, fraud, abuse, or non-compliance with state or federal law.
- f. The accuracy of data submitted in the DSN Provider Report will be periodically validated against available sources. If data for more than 10 percent of providers is incorrect for individual data elements, or if providers are listed who do not have written agreements to provide services to

Contractor’s members, OHA may require Contractor to implement a Corrective Action Plan, or issue penalties or sanctions associated with failure to maintain an adequate provider network.

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

To implement and formalize coordination and ensure relationships exist between Contractor and publicly funded health care and service programs, Contractor shall complete the following table and submit it to the OHA Contract Administration Unit by July 1<sup>st</sup> of every year, and provide additional information upon OHA request.

Name of publicly funded program	Type of public program [(e.g., county mental health dept.)]	County in which program provides services	Does Contractor have a Memorandum of Understanding? [Description of the services provided in relation to Contractor’s services]	What has been the involvement of the public program in Contractor’s operations (on the board, on the Community Advisory Council, on Quality Assurance Committee, specify if subcontract, etc.)?
	Local Mental Health Authority			
	Community Mental Health Programs			
	Type B AAA			
	State APD district offices			
	Local public health authority			

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

To implement and formalize coordination and ensure relationships exist between Contractor and the following entities, Contractor shall provide the following information in a brief narrative report or table and submit to the OHA Contract Administration Unit by July 1<sup>st</sup> of every year, and provide additional information upon OHA request.

- (1) Referral and cooperative arrangements with culturally diverse social and support services organizations, required to be established by Exhibit B, Part 4, Subsection (5)(c).
- (2) Cooperative arrangements and agreements to provide for medications with residential, nursing facilities, foster care and group homes, required by Exhibit B, Part 4, Subsection (5)(e).

- (3) Cooperative arrangements and agreements with DHS Child Welfare offices to assure timely assessments for Member children placed under Child Welfare custody, as required by Exhibit B, Part 2, Subsection(4)(m)(3)(g).

## 6. Hospital Network Adequacy

- a. This Hospital Adequacy Report is an annual report that details Hospital admissions and paid amounts at Contracted Hospitals and Hospital admissions at Non-Contracted Hospitals. The Hospital Adequacy Report will also include the Contractor's total outpatient costs at Contracted Hospitals and the Contractor's total outpatient costs at Non-Contracted Hospitals. Contractor shall submit to the OHA Contract Administration Unit (CAU) by March 31 following the end of the calendar year reporting period. The Hospital Adequacy Report template is available on the Contract Reports Web Site. OHA will review and analyze non-contracted claims by Contractor annually to determine if all Hospital services are adequately represented.
- b. Contractor shall develop and maintain an adequate Hospital network for a full range of services to sufficiently meet the needs of the Contractor's Members.

### (1) Definitions:

**Contracted Hospital** - in this Exhibit G means a Hospital that is a Subcontractor.

**Non-Contracted Hospital** – in this Exhibit G means a Hospital that is not a Subcontractor.

- (2) The following benchmarks will be monitored and evaluated to assess the adequacy of a Hospital network:
  - a. A minimum of 90% of Contractor's total inpatient admissions (excluding all outpatient services) shall be provided in Hospitals under contract with the Contractor.
  - b. A minimum of 90% of Contractor's total dollars paid for all outpatient services (excluding amounts paid for inpatient admissions) shall be provided in Hospitals under contract with the Contractor.
- (1) In those instances where the percentage of Non-Contracted Hospital services are below the benchmarks or the OHA review of the Contractor's annual report of Hospital admissions by DRG indicates Contractor's Hospital network is not adequate, OHA shall determine if the Contractor and Hospital(s) have both made a good faith effort to contract with each other.

The determination of good faith shall consider the following:

- (a) The amount of time the Contractor has been actively trying to negotiate a contractual arrangement with the Hospital(s) for the services involved;
- (b) The payment rates and methodology the Contractor has offered to the Hospital(s);
- (c) The payment rates and methodology the Hospital has offered to the Contractor;
- (d) Other Hospital cost associated with non-financial contractual terms the Contractor has proposed including prior-authorization and other utilization management policies and practices;
- (e) The Contractor's track record with respect to claims payment timeliness, overturned claims, denials, and Hospital complaints;
- (f) The Contractor's solvency status; and

- (g)** The Hospital(s)' reasons for not contracting with the Contractor.
- (h)** If OHA determines that the Contractor has made a good faith effort to contract with the Hospital, OHA shall modify the benchmark calculation, if necessary, for the Contractor to exclude the Hospital so the Contractor is not penalized for a Hospital's failure to contract in good faith with the Contractor.
- (i)** If OHA determines that the Contractor did not make a good faith effort, to negotiate and enter into reasonable contracts, OHA may invoke the following remedies (until such time that the Contractor achieves the benchmarks or provides documentation to OHA that it has an adequate Hospital panel):

  - (1)** Monthly reporting;
  - (2)** Partial withholding of CCO Payments (to be returned retroactively to the Contractor upon achieving compliance or termination/non-renewal of the contract);
  - (3)** Sanctions described elsewhere in this Contract; and finally,
  - (4)** Termination or non-renewal of this Contract.

## Exhibit H – Value Based Payment

Contractor shall demonstrate, as specified below, how it will use Value-based payment methodologies alone or in combination with delivery system changes to achieve better care, controlled costs, and better health for Members.

Contractor shall implement a schedule of Value-based payments, with benchmarks and evaluation points identified that demonstrate direct support for transformation of care delivery and the sustainability of care innovations across the care continuum.

### 1. VBP minimum threshold

Starting on the effective date of this Contract, Contractor shall make at least 20% of its projected annual payments to its providers in contracts that include a value-based payment component as defined by the Health Care Payment Learning and Action Network’s (LAN’s) “Alternative Payment Model Framework White Paper Refreshed 2017” (<https://hcp-lan.org/apm-refresh-white-paper/>), Pay for Performance LAN category 2C or higher. OHA will assess adherence retrospectively. The denominator in this calculation is the total dollars paid (claims and non-claims-based payments) for medical, behavioral, oral, prescription drugs and other health services. Administrative/overhead expenses, profit/margin, and other non-service-related expenditures are excluded from the calculation.

In addition to the [LAN Framework](#), Contractor shall use the Value-based payment Roadmap for Coordinated Care Organizations and the OHA Value-based Payment Roadmap Categorization Guidance for Coordinated Care Organizations reports to enter the appropriate LAN VBP category for each payment model in the [RFA VBP Data Template](#).

### 2. Expanding VBP beyond primary care to other care delivery areas

- a. Contractor shall develop new, or expanded from existing contract, VBPs in care delivery areas which include hospital care, maternity care, children’s health care, behavioral health care, and oral health care. The term “expanded from an existing contract” includes, but is not limited to, an expansion of a CCO’s existing contract such that more providers and/or members are included in the arrangement, and/or higher level VBP components are included. Prior to the effective date of this Contract, Contractor will receive final specifications of care delivery area VBPs, including required reporting metrics, from OHA.
- b. Required VBPs in care delivery areas must fall within LAN [Category 2C \(Pay for Performance\) or higher](#) through the duration of the CCO 2.0 period. Contractor shall plan to implement care delivery area VBPs, according to the following schedule: In 2020, Contractor shall develop 2 new or expanded VBPs. The two new VBPs shall be in two of the listed care delivery areas, and one of the areas must be either hospital care or maternity care. Contractor may design new VBPs in both hospital care and maternity care. A VBP may encompass two care delivery areas; e.g. a hospital maternity care VBP that met specifications for both care delivery areas could count for both hospital care and maternity care delivery areas.
  - (1) By 2021, Contractor shall implement two new or expanded VBPs, developed in previous years.
  - (2) By 2022, Contractor shall implement a new VBP in one additional care delivery area. By the end of 2022, new VBPs in both hospital care and maternity care shall be in place.
  - (3) By 2023 and 2024, Contractor shall implement one new VBP each year in each of the remaining care delivery areas.
  - (4) By the end of 2024, Contractor shall implement new or expanded VBPs in all five care delivery areas.

### 3. Patient-Centered Primary Care Home (PCPCH) VBP requirements

- a. Contractor shall provide per-member-per-month (PMPM) payments to its PCPCH clinics as a supplement to any other payments made to PCPCHs, be they fee-for-service or VBPs. Contractor shall also vary the PMPMs such that higher-tier PCPCHs receive higher payments than lower-tier PCPCHs. The PMPMs must be meaningful amounts, increasing each year over the five-year Contract.
- b. The PCPCH PMPM payment counted for this requirement must be at a LAN Category 2A (Foundational Payments for Infrastructure & Operations) level, as defined by the LAN Framework. Unless combined with a LAN Category 2C VBP or higher, these payment arrangements would not count toward the annual CCO VBP minimum threshold or CCO annual VBP targets.

### 4. VBP Targets by Year

- a. Contractor must increase annually the level of payments that are value-based through the duration of the CCO 2.0 period. Contractor must meet minimum annual thresholds, according to the following schedule:
  - (1) For services provided in 2021, no less than 35% of Contractor's payments to providers must be in the form of a VBP and fall within LAN Category 2C (Pay for Performance) or higher;
  - (2) For services provided in 2022, no less than 50% of Contractor's payments to providers must be in the form of a VBP and fall within LAN Category 2C (Pay for Performance) or higher;
  - (3) For services provided in 2023, no less than 60% of Contractor's payments to providers must be in the form of a VBP and fall within LAN Category 2C (Pay for Performance) or higher, and no less than 20% of the CCO's payments to providers must also fall within LAN Category 3B (Shared Savings and Downside Risk) or higher. These payments will apply towards the annual CCO VBP targets.
  - (4) For services provided in 2024, no less than 70% of the CCO's payments to providers must be in the form of a VBP and fall within LAN Category 2C (Pay for Performance) or higher, and no less than 25% of the CCO's payments to providers must also fall within LAN Category 3B (Shared Savings and Downside Risk) or higher. These payments will apply towards the annual CCO VBP targets.

### 5. Contractor Data Reporting

Contractor shall submit VBP data using [The Health Care Payment Learning and Action Network \(LAN\) categories](#) and OHA Value-based Payment Roadmap Categorization Guidance for Coordinated Care Organizations to categorize VBP arrangements. Contractor shall implement the VBP plan submitted as part of its Application. Contractor shall comply with the following reporting requirements:

- a. OHA desires to ensure that linkage of quality to payment is accomplished with integrity both in terms of size of reward for performance and demonstration for excellence and meaningful improvement to receive the awards. As outlined above, OHA may ask the Contractor to provide detailed information on the size of the incentive payment within the overall contract to ensure that there is a meaningful level of incentive to the provider to improve overall quality performance. Contractor shall describe the specific quality metrics from the [HPQMC Aligned Measures Menu](#), or HPQMC Core Measure Set, if developed in future years, that will be used, including the established benchmarks that will be used for performance-based payments to

providers and other relevant details; or if the aligned measure set does not include appropriate metric/s for planned VBP, Contractor may request approval from OHA to use other metrics, preferably those defined by the [National Quality Forum \(NCF\)](#).

- b.** Should OHA contract with one or more other CCOs serving members in the same geographical area, Contractor shall participate in OHA-facilitated discussions to select performance measures to be incorporated into each CCO's VBP provider contracts for common provider types and specialties. OHA shall inform the Contractor of the provider types and specialties for which the performance measures shall be discussed. Each CCO shall incorporate all selected measures into applicable provider contracts.
- c.** By September 30, 2020, Contractor shall submit payment arrangement data via APAC's Appendices G and H. Please see APAC Reporting Guide for addition information.

Report PCPCH VBP details including:

- (1)** Payment differential and/or range across the [PCPCH tier](#) levels during year CY 1 (2020);
  - (2)** Proposed payment differential and/ or range by PCPCH tier levels over CY 1(2020) through CY2 (2021);
  - (3)** Rationale for approach (including factors used to determine the rate such as rural /urban, social complexity).
  - (4)** How the payments meaningfully support clinics' efforts to support patient-centered care.
- d.** By Spring/Summer 2020, Contractor's executive leadership team shall engage in interviews with OHA to:
    - (1)** Describe how the first year of activities and VBP arrangements compare to that which was reported in the RFA, including detailed information about VBP arrangements and LAN categories;
    - (2)** Discuss the outcome of the Contractor's plan for mitigating adverse effects of VBPs and compare/describe any modifications to that which was reported in the RFA;
    - (3)** Report implementation plans for the two care delivery areas that will start in 2021; and
    - (4)** Any additional information requested by OHA on VBP development and implementation.

OHA may publish each Contractor's data such as the actual VBP percent of spending that is LAN category 2C or higher and spending that is LAN category 3B or higher, as well as data pertaining to the Contractor's care delivery areas, PCPCH payments, and other information pertaining to VBPs. OHA will not publish specific payments amounts from an Contractor to a specific provider.

## **Exhibit I – Grievance and Appeal System**

Contractor shall establish and maintain a system for Members, supported by written policies and procedures, under which a Member, or a representative acting on his or her behalf, may challenge any Adverse Benefit Determination made by the Contractor, as defined in 42 CFR 438.400 and file a grievance for any matter other than an Adverse Benefit Determination. Contractor shall maintain its Member Grievance and Appeal System in accordance with this exhibit, OAR 410-141-3225 through 410-141-3255 and 42 CFR 438.400 through 438.424. Grievance and appeal system means the processes the Contractor implements for grievances, Adverse Benefit Determinations, appeals of an adverse benefit determination, and access to contested case hearing, as well as the processes to collect and track information about them. For the purposes of this Exhibit references to Member means a member, the member's representative, a provider acting on behalf of the member and with member's written consent, or a representative of a deceased member's estate.

### **1. Grievance and Appeal System**

Contractor have only one level of appeal for members and members must complete the appeals process with the CCO prior to requesting a state Contested Case Hearing.

#### **a. Filing Requirements**

- (1) A Member may file a Grievance or an Appeal with the Contractor;
- (2) A Member may file a Grievance with OHA or the Contractor. OHA will promptly send the Grievance to the Contractor;
- (3) A Member may request a Contested Case Hearing with OHA after receiving notice that a Contractor Appeal has been upheld, except where Contractor fails to adhere to the notice or timing requirements in 42 CFR 438.408, the Member is deemed to have exhausted the Contractor's appeals process. The Member may initiate a hearing.

#### **b. Timing**

- (1) A member may file a grievance at any time.
- (2) A member may file an Appeal within 60 days from the date on the Notice of Adverse Benefit Determination
- (3) A member may request a Contested Case Hearing within 120 days from the date on the Notice of Appeal Resolution when Contractor's adverse benefit determination is upheld or, if the Authority dees that the Member has exhausted the Contractor's appeals process.

#### **c. General System Requirements**

- (1) Contractor shall permit Member to file a Grievance either orally or in writing; and
- (2) Contractor shall permit Member to file an Appeal either orally or in writing consistent with the requirements in OAR 410-141-3245
- (3) Contractor shall ensure oral requests for appeal of an adverse benefit determination are treated as appeals to establish the earliest possible filing date;
- (4) Contractor shall Provide Members reasonable assistance in completing forms and taking other procedural steps. This assistance includes, but is not limited to providing Certified or Qualified Health Care Interpreter services and toll-free numbers that have adequate TTY/TTD and Certified or Qualified Health Care Interpreter capability; The CCO shall not discourage a member from using any aspect of the grievance system or take punitive action against a provider who requests an expedited resolution or supports a member's grievance or appeal.

- (5) Contractor shall make grievance and appeal forms available and accessible to members (OAR 410-141-3230) in all administrative offices.
- (6) Individuals who make decisions on grievances and appeals whether employed directly by the Contractor or through a subcontractual agreement, must be individuals—
  - (a) Who were neither involved in any previous level of review or decision-making nor a subordinate of any such individual.
  - (b) Who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease.
    - i. An appeal of a denial that is based on lack of medical necessity.
    - ii. A grievance regarding denial of expedited resolution of an appeal.
    - iii. A grievance or appeal that involves clinical issues.
- (7) Contractor Appeal process shall take account all comments, documents, records, and other information submitted by the Member or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.
- (8) If the Contractor delegates part of the grievance and appeal process to a subcontractor or participating provider, the Contractor must:
  - i. Validate that the subcontractor meets the requirements consistent with this rule and OAR 410-141-3225 through 410-141-3255;
  - ii. Monitor the subcontractor's performance on an ongoing basis;
  - iii. Perform a formal compliance review at least annually to assess performance, deficiencies, or areas for improvement; and
  - iv. Cause subcontractor to take corrective action for any identified areas of deficiencies that need improvement.
  - v. Include data collected by subcontractors in its analysis of grievance system provided to OHA, and ensure data is reviewed by Contractor's Compliance Committee, consistent with contractual requirements for CCO quality improvement.
- (9) Contractor shall not delegate Adjudication of an Appeal to a Subcontractor

## 2. Grievances

- a. Contractor shall permit a member may file a grievance at any time, orally or in writing with the CCO or OHA; who will promptly send the grievance to the CCO. Grievance includes a Member's right to dispute an extension of time proposed by the contractor or its delegates to make an authorization decision.
- b. Upon receipt of a grievance, the Contractor shall comply with grievance process and timing requirements in OAR 410-141-3230 and 410-141-3235.
- c. Contractor's notice of grievance resolution shall comply with OHA's formatting and readability standards in OAR 410-141-3300 and 42 CFR §438.10.
- d. A member grievance that involve a clinical issue or a denial based on medical appropriateness or medical necessity, or for denial of an expedited appeal resolution, must be reviewed by

individuals with appropriate clinical expertise, as determined by OAR 410-141-3230 in treating the enrollee's condition or disease.

- e. A member grievance related to a member's entitlement of continuing benefits in the same manner and same amount during the transition of transferring from one CCO to another CCO for reasons defined in OAR 410-141-3080 (15), shall be recorded by the Contractor and the Contractor shall work with the receiving, or sending, CCO to ensure continuity of care during the transition.
- f. Contractor shall cooperate and cause its subcontractor to cooperate, with investigations and resolution of a Grievance by the CSU or OHA's Ombudsman, timely; as expeditiously as the enrollee's health conditions required, and no longer the State.- established timeframes in the contract.
- g. The CCO shall address the analysis of its grievances in the context of quality improvement activity, consistent with OAR 410-141-3230 and incorporate analysis into contract deliverables to OHA.
- h. The CCO must resolve each grievance and provide notice of the disposition as expeditiously as the member's health condition requires but no later than the following timeframes:

(1) Resolution for Grievances

Notify the Member, within five Business Days from the date of the Contractor's receipt of the Grievance, of one of the following:

- (a) A decision on the Grievance has been made and what that decision is; or
- (b) That there will be a delay in the Contractor's decision, of up to 30 days. The written notice shall specify why the additional time is necessary.

(2) Notice of Grievance Resolution

- (a) Contractor shall respond in writing to all Member grievances. In addition to written response, the Contractor may also respond orally.
- (b) Notice of resolution shall address each aspect of the Member's Grievance and explain the reason for the Contractor's decision.
- (c) Notice language shall be sufficiently clear that a layperson could understand the disposition of the grievance and the process for members who are dissatisfied to present the grievance to the Department of Human Services (DHS) Client Services Unit or OHA's Ombudsman.
- (d) Notice shall include information on how a Member who is dissatisfied with the disposition of a grievance may present the Grievance to OHP Client Services Unit (CSU) toll free at 800-273-0557 or OHA's Ombudsman at 503-947-2346 or toll free at 877-642-0450.

**3. Notice of Adverse Benefit Determination**

When Contractor has made or intends to make an adverse benefit determination the Contractor shall notify the requesting Provider and mail written Notice to the Member.

- a. Contractor Notice form must be reviewed and approved by OHA prior to use.
- b. Contractor shall only use OHA approved Notice format. The Notice shall meet the language and format requirements in Exhibit B, Part 3, Section 4 and be consistent with the requirements of

OAR 410-141-3280, 410-141-3300 and 42 CFR 438.10. Contractor written notice shall be translated for Members who speak prevalent non-English languages, as defined in 42 CFR 438.10 (c), and all notices must include language clarifying that oral interpretation is available for all languages and how to access it, and include at a minimum the following information:

- (1) Date of the notice;
- (2) Contractor name, address and phone number;
- (3) Name of the member's Primary Care Practitioner (PCP), Primary Care Dentist (PCD), or behavioral health professional, as applicable;
- (4) Member's name, address and ID number;
- (5) Service requested or previously provided and adverse benefit determination the MCE made or intends to make, including whether the MCE is denying, terminating, suspending, or reducing a service or denial of payment
- (6) Date of the Service or date service was requested by the provider or member,;
- (7) Name of the provider who performed or requested the service;
- (8) Effective date of the adverse benefit determination if different from the date of the Notice;
- (9) Whether the CCO considered other conditions such as co-morbidity factors if the service was below the funding line on the OHP Prioritized List of Health Services.

Clear and through explanation for the specific reasons for the adverse benefit determination reason.

- (10) A reference to the specific sections of the statutes and administrative rules to the highest level of specificity for each reason and specific circumstances identified in the Notice;
- (11) The Member's right to file an Appeal, and the procedures to exercise that right;
- (12) The Member's right to request a Contested Case Hearing, and the procedures to exercise that right,
- (13) The circumstances under which an expedited Appeal resolution and an expedited Contested Case hearings are available and how to request;
- (14) The Member's right to have benefits continue pending resolution of the Appeal, how to request that benefits be continued, and the circumstances under which the Member may be required to pay the costs of the services.
- (15) The Member's right to be provided upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the Member's Adverse Benefit Determination, and;
- (16) Contractor shall include with Notice the appropriate forms as outlined in OAR 410-141-3240.

**c.** Contractor shall, for every Notice, meet the following timeframes:

- (1) For termination, suspension, or reduction of previously authorized Covered Services:
  - (a) The Notice shall be mailed at least 10 days before the date the Adverse Benefit Determination takes effect, except as permitted under Items (b) or (c) below.



timeframe and inform the Member of the right to file a Grievance if he or she disagrees with that decision.

- (iii) The Contractor shall issue and carry out its Prior Authorization determination as expeditiously as the Member's health condition requires and no later than the date the extension expires.
- (4) For Authorization decisions not reached within the appropriate timeframes (which constitutes a adverse benefit determination), the Notice shall be mailed on the date that the Authorization timeframe expires;

#### 4. Handling of Appeals

Contractor shall have written policies and procedures that meet the requirements of OAR 410-141-3230, 410-141-3245 and 410-141-3246 and address how the CCO will accept, process and respond to Appeals. Contractor shall have one level of Appeal for Members.

##### a. General Requirements

- (1) Contractor shall acknowledge receipt of each Appeal;
- (2) Contractor procedures shall require that Individuals who make decisions on Appeals are individuals:
  - (a) Who were not involved in any previous level of review or decisions-making;
  - (b) Who are not subordinates of any individual involved in a previous level of review or decision making; and
  - (c) Who, if deciding any of the following, are Health Care Professionals as defined in OAR who have the appropriate physical health, behavioral health (which includes mental health and Substance Use Disorders), and oral health clinical expertise, in treating the Member's condition or disease:
    - (i) An Appeal of a denial that is based on lack of Medically Appropriate services,
    - (ii) An Appeal that involves clinical issues.

##### b. Requirements for Appeals

Contractor process for Appeals shall:

- (1) Provide that oral inquiries seeking to Appeal an Action are treated as Appeals, in order to establish the earliest possible filing date, and must be confirmed in writing, unless the Member or the Provider requests an expedited resolution.
- (2) Provide the Member a reasonable opportunity to present evidence and allegations of fact or law, in person as well as in writing. The Contractor shall inform the Member of the limited time available sufficiently in advance of the resolution timeframe for appeals as specified in §438.408(b) and (c) in the case of expedited resolution.
- (3) Provide the Member, upon request a copy of the Member's case file, including medical records other documents and records, and any new or additional evidence considered, relied upon, or generated by the CCO (or at the direction of the CCO) in connection with the appeal of the adverse benefit determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals as specified in 42 CFR §438.408 (b)(c).

- (4) Contractor shall provide Appeal information to Members in accordance with Exhibit B Information Materials and Education of Members and Potential Members and, at a minimum:
  - (a) The 60-day time limit for filing an Appeal
  - (b) The toll-free numbers that the Member can use to file a Grievance or Appeal by phone;
  - (c) The availability of assistance in the filing process;
  - (d) The rules that govern representation at the hearing;
  - (e) The right to have an Attorney or Member Representative present at the 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) Contractor shall 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) The Contractor must document appeals and maintain a record as described in OAR 410-141-3245.

**c. Appeal Resolution and Notification**

**(1) General Requirements for Resolution**

- (a) Contractor shall resolve each Appeal, and provide notice to the Member, as expeditiously as the Member's health condition requires and within the timeframes in this section.
- (b) Adjudication of member Appeals must be performed by the Contractor. Adjudication may not be delegated or subcontracted; and
- (c) If Contractor fails to adhere to the notice and timing requirements in 42 CFR §438.408, the member is considered to have exhausted the Appeals process and may initiate a contested case hearing.

**(2) Standard Resolution for Appeals**

Contractor shall resolve Standard Appeals as expeditiously as the Member's health condition requires and no later than 16 days from the day the Contractor receives the Appeal. The Contractor may extend this timeframe by up to 14 days if:

- (a) The Member requests the extension; or
- (b) The Contractor shows (to the satisfaction of OHA, upon its request) that there is need for additional information and how the delay is in the Member's interest.

If the Contractor extends the timeframes, it shall, for any extension not requested by the Member, give the Member a written notice, and make reasonable effort to give the Member oral notice of the reason for the delay. Contractor shall resolve appeal no later than the expiration date of the extension.

**(3) Expedited Resolution for Appeals**

The Member may file an expedited Appeal either orally or in writing.

- (a) For cases in which a Provider indicates, or the Contractor determines, that following the standard Appeal timeframe could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function, the Contractor shall make an expedited decision
- (b) Contractor shall resolve expedited Appeals , as expeditiously as the Member's health condition requires, and no later than 72 hours from when the Contractor received the request for an expedited Appeal.
- (c) The Contractor may extend the timeframe by up to 14 days if:
  - (i) The Member requests the extension; or
  - (ii) The Contractor shall show (to the satisfaction of OHA, upon its request) that there is need for additional information and how the delay is in the Member's interest.
- (d) If the Contractor extends the timeframes, it shall, for any extension not requested by the Member, give the Member a written notice within in two days of the reason for the delay, and make reasonable effort to give the Member oral notice The Member has the right to file a grievance if they disagree with the extension. Contractor shall resolve appeal no later than the expiration date of the extension.
- (e) If the Contractor denies a request for an expedited Appeal, the Contractor shall:
  - (i) Transfer the Appeal to the time frame for standard resolution. Contractor shall resolve the appeal no later than 16 days from the day the Contractor receives the Appeal with possible 14-day extension in accordance with OAR 410-141-3246; and
  - (ii) Make reasonable efforts to give the Member prompt oral notice of the denial, and follow-up within two days with a written notice.  
  
The written notice must state the right of a Member to file a grievance with the CCO if he or she disagrees with that decision
- (f) If the contractor approves a request for expedited appeal but denies the services or items requested in the expedited appeal, the CCO shall:
  - (i) Inform the member of their right to request an expedited Contested Case Hearing and send the member a Notice of Appeal Resolution, Hearing Request and Information forms as outlined in OAR 410-141-3247.
- (g) Contractor shall ensure that punitive action is neither taken against a Provider who requests and expedited resolution or supports a Member's Appeal.

**(4) Notice of Resolution of Appeals**

Contractor notice of resolution shall be in a format approved by OHA and written in language that, at a minium, meet the standards described in 42 CFR 438.10. For notice of an expedited resolution, Contractor shall make reasonable effort to provide oral notice. The written notice of resolution of an Appeal shall include the following:

- (a) The results of the resolution process and the date the 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 120 days from the date of the Contractor’s Notice of Appeal Resolution and how to do so, which includes sending the Notice of Hearing Rights (DMAP 3030) and the Hearing Request Form (MSC 0443);
  - (iii) The right to continue to receive benefits pending a Contested Care Hearing and how to do so;
  - (v) Information explaining how if the Contractor’s Adverse Benefit Determination is upheld in a Contested Case Hearing, the Member may be liable for the cost of any continued benefits.

## 5. Contested Case Hearings

Contractor grievance and appeal system shall provide its Members access to a contested case hearing. Members must complete Contractor’s appeal process prior to receiving a hearing with OHA. In the case where a CCO fails to adhere to the notice or timing requirements, OAR 410-141-3225 through 410-141-3246, the enrollee is deemed to have exhausted the CCO appeals process and may initiate a Contested Case Hearing.

- a. Contested Case Hearing requests must be filed by a Member with Contractor or OHA, no later than 120 days from the date of the notice of Appeal resolution.
- b. Upon receipt of a request for a contested Case Hearing, Contractor shall: Date stamp the hearing request with the date of receipt; immediately transmit the request to OHA with a copy of Contractor’s notice of Appeal Resolution as described in this exhibit.
- c. Contractor shall submit the required documentation described in OAR 410-141-3247 and 410-141-3245 to the OHA Hearings unit within two business days of the request.
- 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 or health or ability to attain, maintain or regain maximum function may request an expedited Contested Case Hearing, as described in OAR 410-141-3248.

## 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 while an appeal or contested case hearing is

pending. As used in this section, “timely” filing means filing on or before the later of the following:

- (1) Within 10 days after the date of the Notice of adverse benefit determination; or
- (2) The intended effective date of the Action proposed in the notice.

**b.** The Contractor shall continue the Member’s benefits if:

- (1) The Member or Member’s Representative files the Appeal or Contested Case Hearing request timely;
- (2) The Appeal or Contested Case Hearing request involves the termination, suspension, or reduction of a previously authorized services;
- (3) The Services were ordered by an authorized Provider;
- (4) The period covered by the original authorization has not expired; and
- (5) The Member timely files for continuation of benefits.

**c. Duration of Continued Benefits**

**(1) Continuation of benefits pending appeal resolution:**

If, at the Member’s request, the Contractor continues or reinstates the Member’s benefits while the Appeal is pending pursuant to 42 CFR 438.402(c) the benefits must be continued until one of the following occurs:

- (a) The Member withdraws the Appeal
- (b) The Contractor issues an Appeal Resolution; or
- (c) The authorization expires or the authorization service limits are met

**(2) Continuation of benefits pending Contested Case Hearing resolution**

If, at the Member’s request, the Contractor continues or reinstates the Member’s benefits while the Contested Case Hearing is pending pursuant to 42 CFR 438.402(c) the benefits must be continued until one of the following occurs:

- (a) The Member does not request a Contested Case Hearing within 10 days from when the Contractor mails the notice of Appeal resolution letter
- (b) The Member withdraws his or her request for hearing;
- (c) A Contested Case Hearing decision adverse to the Member is issued; or
- (d) The authorization expires or authorization service limits are met.

**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 is adverse to the Member, that is, upholds the Contractor’s Adverse Benefit Determination, the Contractor may recover from the Member the cost of the services furnished to the Member while the Appeal or hearing was pending under 42 CFR 431.230 (b), to the extent that they were furnished solely because of the requirements of this section.

## **7. Implementation of Reversed Appeal Resolution**

### **a. Services not furnished while an appeal is pending**

If the Contractor or Administrative Law Judge reverses a decision to deny, limit, or delay services that were not furnished while the Appeal or hearing was pending, the Contractor shall authorize or provide, the disputed services promptly, and as expeditiously as the Member's health condition requires but no later than 72 hours from the date it receives the notice reversing the determination.

### **b. Services furnished while an appeal is pending**

If the Contractor or Administrative Law Judge reverses a decision to deny authorization of services, and the Member received the disputed services while the Appeal or hearing was pending, the Contractor shall pay for the services.

## **8. Final Order on Contested Case Hearings**

OHA will resolve the case ordinarily within 90 days from the date the 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 410-141-3245, 410-141-3255 and 42 CFR 438.416. Contractor shall fully and timely comply with all records requests. Contractor shall fully and promptly comply with OHA monitoring and oversight.

**b.** Contractor shall maintain record, in a central location accessible to OHA and CMS upon request, for each grievance and appeal. The record shall include, at a minimum:

A general description of the reason for the appeal or grievance;

- (1) The members name, ID;
- (2) The date the member, or members representative, or provider filed the grievance or appeal
- (3) Notice of Adverse Benefit Determination;
- (4) If filed in writing, the Appeal or Grievance;
- (5) If an oral filing was received, documentation that the Grievance or Appeal was received orally;
- (6) Records of the review or investigation at each level of the appeal, grievance, or hearing;
- (7) Notice of resolution of the Grievance or Appeal, including dates for each level; and
- (8) Resolution including all written decisions and 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 appeal process; and
- (9) All written decisions and copies of all correspondence with all parties to the Grievance, Appeal or hearing.

**c.** The contractor shall provide to OHA Contract Administration Unit 45 days following the end of each calendar quarter the following documentation, at a minimum:

- (1) A Grievance and Appeal Log in a format provided by OHA and available at <http://www.oregon.gov/OHA/healthplan/pages/CCO-Contract-Forms.aspx>
  - (2) Samples of Notices of Adverse Benefit Determination and corresponding prior authorization documentation. Prior Authorization Record shall include, at a minimum: date of the request for the service, the diagnoses submitted, the CPT or HCPC (treatment) codes being requested, and any comorbid diagnosis 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. . The sample size is twenty per quarter. Contractor shall submit records selected by OHA no later than 14 days following receipt of request.
  - (3) All Adverse Benefit Determination Notices for ABA and Hepatitis C
- d. The Contractor shall submit a Grievance System Narrative Report, in a format provided by OHA and available at <http://www.oregon.gov/oha/HSD/OHP/Pages/CCO-Contract-Forms.aspx>. The Contractor shall use data collected from monitoring of its grievance and Appeal system to analyze its System., including all grievances and appeals data reported by the CCO in the Grievance and Appeal Log. The shall demonstrate how the CCO uses data collected by the CCO and its subcontractors, to maintain an effective process for monitoring, evaluating and improving the access, quality and appropriateness of services provided to members. .
  - e. The Contractor shall submit to OHA Contract Administration Unit annually, on January 31<sup>st</sup>, Contractor Grievance and Appeal system policies and procedures. Documentation shall address comprehensive System maintained by the CCO to comply with OAR 410-141-3225 through 410-141-3255.
  - f. The Contractor shall promptly comply with all Grievance and appeal records requests from OHA, CMS, EQRO or other external auditors. Contractor shall submit records to OHA Contract Administration Unit, no later than 14 days following Contractor receipt of a request, except where request is related to Contested Case Hearing where Contractor shall submit required documentation within 24 hours for an expedited hearing and 2 days for a standard hearing. Contractor is accountable for collection and submission of grievance and appeal records maintained in part, or in full, by Subcontractors.
  - g. Contractor shall monitor data collected from its grievance system by the CCO and its Subcontractors, internally on a monthly basis for completeness and accuracy
  - h. The Contractor shall submit records of monitoring of Grievance and Appeal system delegated, in part or in full, to its Subcontractors to OHA, federal, state, and OHA contracted auditors, upon request. Contractor records shall provide evidence of compliance with provisions in this Contract for Subcontractors and 42 CFR 438.230. Records shall include any Corrective Actions initiated by Contractor as a result of Subcontractor monitoring, up to and including termination of Subcontractor. Contractor shall submit records to OHA Contract Administration Unit, no later than 14 calendar days following receipt of the request or in a timeframe established by requesting party.
  - i. Contractor shall revise grievance and appeal system policies and procedures within 30 days of notification by OHA, CMS or EQRO of non-compliance with Federal, State or Contract grievance and appeal system requirements. Contractor shall cause Subcontractors delegated Work of grievance and appeal system to revise grievance and appeal system policies and procedures within 30 days of notification by OHA, CMS or EQRO of non-compliance with

Federal, State or Contract grievance and appeal system requirements. Contractor shall submit revised materials to OHA for review and approval.

- j.** Contractor shall revise grievance and appeal system member Notices within 30 days of notification by OHA, CMS or EQRO of non-compliance with Federal, State or Contract requirements. Contractor shall cause Subcontractors to revise grievance and appeal system member Notices within 30 days of notification by OHA, CMS or EQRO of non-compliance with Federal, State or Contract grievance and appeal system requirements. Contractor shall submit revised materials to OHA for review and approval.
- k.** OHA will monitor Contractor compliance and provide Contractor notice of non-compliance, as needed. Contractor is accountable for correcting any and all aspects of its grievance and appeal system identified as non-compliant, whether Work is performed by Contractor or delegated by Contractor to Subcontractors. OHA may proceed with placing Contractor on a work plan or Corrective Action up to and including sanctions and termination of Contractor managed care contact. Contractor shall provide evidence of correction to OHA Contract Administration unit within 30 days of receipt of notice.

## **Exhibit J - Health Information Technology**

### **1. Health Information Technology Requirements**

- a.** Contractor shall maintain a health information system that: 1) meets the requirements of this Contract; 2) meets the requirements of 42 CFR 438.242 and section 1903(r)(1)(F) of PPACA; and 3) will collect, analyze, integrate and report data that can provide information on areas including but not limited to:
  - (1)** Names and phone numbers of the Member's Primary Care Physician or clinic;
  - (2)** Client Process Monitoring System Forms data. OHA is closing the CPMS system and replacing it with the Measures and Outcome Tracking System (MOTS).
  - (3)** Copies of completed Request for LTPC Determination Forms;
  - (4)** Evidence that the Member has been informed of rights and responsibilities;
  - (5)** Grievance, Appeal and hearing records;
  - (6)** Utilization of services;
  - (7)** Disenrollment for other than loss of Medicaid eligibility;
  - (8)** Covered Services provided to Members, through encounter data system or other documentation system; and
  - (9)** Member characteristics, including but not limited to race, ethnicity and preferred language in accordance with OHA and DHS standards.
- b.** Contractor shall collect data at a minimum on:
  - (1)** Member characteristics and Provider characteristics as required in Exhibit G;
  - (2)** Member Enrollment; and
  - (3)** Services provided to Members for pharmacy, and encounter data reporting.
- c.** Contractor shall ensure claims data received from Providers, either directly or through a third party submitter, is accurate, truthful and complete in accordance with OAR 410-120-1280 and OAR 410-141-3420 by:
  - (1)** Verifying accuracy and timeliness of reported data;
  - (2)** Screening data for completeness, logic and consistency;
  - (3)** Submitting the certification contained in Exhibit B, Part 8, Section 7;
  - (4)** Collecting service information in standardized formats in accordance with OHA Electronic Data Transmission (EDT) procedures in OAR Chapter 943 Division 120; and
  - (5)** Confirming Member's responsibility for its portion of payment as stated in 42 CFR 438.10
  - (6)** Contractor shall provide to OHA, upon request, verification that Members were contacted to confirm that billed services were provided in accordance with 42 CFR §455.20 and 433.116 (e) and (f) by:
    - (a)** Providing a notice, within 45 days of the payment of a claim, to all or a sample group of the Members who received services;

- (b) The notice must, based on information from the Contractor’s claims payment system, specify:
          - (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; and
        - (c) The sample shall not include specially protected information such as genetic, mental health, alcohol and drug or HIV/AIDS.
- d. Contractor shall make all collected and reported data available upon request to OHA and CMS (as specified in 42 CFR §438.242).
- e. Contractor shall report on proportion of contracted physical, behavioral and oral health providers adopting EHRs (including those with any EHR, Certified EHR, and 2015 Certified EHR; see <https://chpl.healthit.gov/> and <https://www.healthit.gov/topic/certification-ehrs/2015-edition>); proportion of contracted physical, behavioral and oral health providers who have access to HIE and proportion using HIE for care coordination; and proportion of contracted physical, behavioral and oral health providers who have access to, and proportion using, hospital event notifications.

## 2. Health Information Technology (HIT) Roadmap

- a. Contractor shall maintain an OHA-approved HIT Roadmap. The HIT Roadmap must contain the information defined in the RFA, and inclusive of Contractor’s activities, milestones and timelines to carry out Section/Items (f)-(k) below. In its HIT Roadmap, Contractor shall describe how it is using HIT to achieve desired outcomes. Contractor shall explain where it is implementing its own HIT systems and where it is leveraging collaborative HIT efforts, such as regional or statewide initiatives.
- b. Contractor shall provide an annual HIT Roadmap update for OHA review and approval.
  - (1) The annual HIT Roadmap update must clearly identify any changes to prior approved HIT Roadmap.
  - (2) The annual HIT Roadmap update must include Contractor attestation to progress made on their HIT Roadmap and provide supporting information on progress made. OHA may request further information to support attestations.
  - (3) As part of the annual HIT Roadmap update, Contractor shall participate in an annual interview. OHA may also request further detail and that discussion of the annual HIT Roadmap update be part of the annual VBP interview.
  - (4) In the event that Contractor does not engage with the annual HIT Roadmap update process or does not achieve an approved updated HIT Roadmap via that process, OHA may offer technical assistance and reserves the right to require corrective action or other consequences including remedies authorized under this contract (See Exhibit D Section 9).
- c. Contractor shall comply with its HIT Roadmap. In the event that Contractor does not comply with an approved HIT Roadmap, OHA may offer technical assistance and reserves the right to

require corrective action or other consequences including remedies authorized under this contract (See Exhibit D Section 9).

- d.** Contractor shall participate as a member in good standing of the HIT Commons, as follows:
  - (1)** Contractor shall maintain an active, signed HIT Commons MOU.
  - (2)** Contractor shall adhere to the terms of the HIT Commons MOU.
  - (3)** Contractor shall pay the annual HIT Commons assessments subject to the payment terms of the HIT Commons MOU.
  - (4)** Contractor shall serve, if elected, on the HIT Commons governance board or one of its committees.
- e.** Contractor's designated representative shall participate in OHA's HIT Advisory Group (HITAG), at least once annually.
- f.** Contractor shall support EHR adoption for its contracted physical, behavioral, and oral health providers.
- g.** Contractor shall support access to health information exchange that enables sharing patient information for care coordination for its contracted physical, behavioral, and oral health providers.
- h.** Contractor shall ensure access to timely hospital event notifications for its contracted physical, behavioral, and oral health providers.
- i.** Contractor shall use hospital event notifications within the CCO, for example, to support care coordination and/or population health efforts.
- j.** Contractor shall use HIT to administer VBP arrangements; support contracted providers with VBP arrangements with actionable data, attribution, and information on performance; and use HIT for population health management.
- k.** Contractor shall report annually to OHA on its activities in this section. Reports shall be submitted for review and approval to OHA. OHA may ask Contractor's contracted providers for information to support the monitoring process. If not otherwise specified, reporting format, definitions, and deadlines will be determined during Readiness Review. Required reporting elements are as follows:
  - (1)** Contractor shall attest that it:
    - (a)** has an active, signed HIT Commons MOU.
    - (b)** adheres to the terms of the HIT Commons MOU.
    - (c)** has paid the annual HIT Commons assessments subject to the payment terms of the HIT Commons MOU.
    - (d)** serves, if elected, on the HIT Commons governance board or one of its committees.
    - (e)** participates in OHA's HITAG, at least annually.
  - (2)** Contractor shall report the EHR(s) vendor/product in use by each of its contracted physical, behavioral, and oral health providers.
  - (3)** Contractor shall report progress on EHR adoption targets via the Performance Expectations reporting described in Exhibit M.

- (4)** Contractor shall report the HIE tool(s) in use by each of its contracted physical, behavioral, and oral health providers.
- (5)** Contractor shall report progress on HIE access targets via the Performance Expectations reporting described in Exhibit M.
- (6)** Contractor shall report on how Contractor used HIT to administer its VBP arrangements in place at the start of the year and provide supporting detail about implementation approach.
- (7)** Contractor shall report on how it used HIT to support contracted providers so they can effectively participate in VBP arrangements, including details on:

  - (a)** How Contractor provided contracted providers with VBP arrangements with timely (e.g. at least quarterly) information on measures used in the VBP arrangements applicable to the contracted providers;
  - (b)** How Contractor provided contracted providers with VBP arrangements with accurate and consistent information on patient attribution;
  - (c)** How Contractor identified, for contracted providers with VBP arrangements, (or provided contracted providers with VBP arrangements with the information needed for those providers to identify) specific patients who needed intervention throughout the year so they could take action before the year-end;
  - (d)** How Contractor provided any other actionable data to contracted providers to support providers' participation in VBP arrangements, including data on risk stratification and member characteristics that can inform the targeting of interventions to improve outcomes;
  - (e)** Percentage of contracted providers with VBP arrangements at the start of the year who had access to these above data;
- (8)** Contractor shall report on how it used HIT for population health management, including:

  - (a)** Report on Contractor's capability to risk stratify and identify and report on member characteristics, including but not limited to past diagnoses and services, that can inform the targeting of interventions to improve outcomes; and
  - (b)** For Years 2-5, Contractor shall report on provision of risk stratification and member characteristics to contracted providers with VBP arrangements for the population(s) included in the arrangement(s).

## **Exhibit L – Solvency Plan and Financial Reporting and Cost**

### **1. Overview of Solvency Plan and Financial Reporting**

#### **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 and OAR 410-141-3340 through 410-141-3395. As part of the proof of financial responsibility, Contractor shall provide assurance satisfactory to OHA that Contractor's provisions against the risk of insolvency are adequate to ensure the ability to comply with the requirements of this Contract.
- (2) Reporting forms and other tools for Contractor's solvency plan and financial reporting are available on the Contract Reports Web Site, and are by this reference incorporated into the Contract.

### **2. Solvency Plan and Financial Reporting**

Terms used in this Section B are defined in OAR 410-141-3345 to 410-141-3395, incorporated by reference herein.

#### **a. Annual Financial Statements and Supplemental Filings**

- (1) Contractor shall submit annual financial statements per OAR 410-141-3365 by March 1 of each year covering the calendar year ending December 31 immediately preceding. All financial statements shall be completed in accordance with NAIC annual statement instructions and shall include supplemental documents as specified therein and as outlined in this section.
- (2) Contractor shall file the financial statements per the instructions on the NAIC Filings website.
- (3) Contractor shall use Statutory Accounting Principles (SAP) in the preparation of all financial statements per OAR 410-141-3365.
- (4) Contractor shall immediately notify OHA of a material change in circumstance from the information contained in the latest-submitted financial statement. See guidelines for amending the financial statement set forth on the NAIC filings website.
- (5) In accordance with NAIC annual statement instructions, an Actuarial Opinion shall be included with the annual statement. Such opinion shall be prepared by a qualified actuary appointed by the Contractor's board of directors and shall set forth the actuary's opinion relating to claim reserves and any other actuarial items.
- (6) Contractor shall prepare and file by March 1 of each year a risk-based capital report as required by OAR 410-141-3360.
- (7) Contractor shall prepare and file by April 1 of each year a plain-language narrative explanation of the financial statements (Management Discussion and Analysis or "MDA"). Such narrative shall follow the outline and guidance for the Management Discussion and Analysis in the annual statement instructions.
- (8) Contractor shall file a holding company registration statement ("Form B filing") as required by OAR 410-141-3385. The Form B filing is due annually on or before April 30.

- (9) Contractor shall file supplemental reports electronically to OHA. OHA shall, via the Contract Reports Web Site, supply Contractor with an Excel workbook containing the Quarterly/Annual Financial Reports (referred to as the “Exhibit L Financial Reporting Template”). Definitions and instructions for completing each report is included within the Exhibit L Financial Reporting Template as well as an annotation as to whether the individual report is due Quarterly or Annually and the respective due dates. Contractor shall submit the Quarterly Financial Reports to OHA through OHA’s secure file transfer protocol (SFTP) site or other report delivery mechanism as specified by OHA.
- (10) Contractor shall prepare and file with its annual statement OHA’s Disclosure of Compensation report included in the Exhibit L Financial Reporting Template.

**b. Financial Statement Filing Information and Resources**

- (1) Contractor shall file the National Association of Insurance Commissioners Annual and Quarterly Blank for Health insurers. Electronic files will be sent to the NAIC and two hard copy filings shall be submitted to OHA.
- (2) Filing instructions and resources are provided at the NAIC filings website.
- (3) A list of NAIC filing software vendors is included on the web site mentioned above.
- (4) Contractor will be subject to any filing fees as imposed by the NAIC to make such filing.

**c. Audited Financial Statements**

- (1) Contractor shall submit Audited Financial Statements through OHA’s secure file transfer protocol (SFTP) site, or other report delivery mechanism as specified by OHA no later than June 1<sup>st</sup> for the year ended December 31 immediately preceding. Audited Financial Statements shall be prepared in the form required of insurers by the Insurance Code, as required by OAR 410-141-3365 and by reference to ORS 731.488 and OAR 836-011-0100 through 836-011-0220.

**d. Quarterly Financial Statements**

- (1) Contractor shall submit quarterly financial statements per OAR 410-141-3365. All financial statements shall be completed in accordance with NAIC annual statement instructions and includes supplemental documents as specified therein and as outlined in this section.
- (2) Contractor shall file the financial statements per the instructions on the NAIC filings website.
- (3) Contractor shall use Statutory Accounting Principles (SAP) in the preparation of all financial statements per OAR 410-141-3365.
- (4) Contractor shall immediately notify OHA of a material change in circumstance from the information contained in the latest-submitted financial statement. See guidelines for amending the financial statement set forth on the NAIC filings website.
- (5) Contractor shall file supplemental reports electronically to OHA. OHA shall, via the Contract Reports Web Site, supply Contractor with an Excel workbook containing the Quarterly/Annual Financial Reports (referred to as the “Exhibit L Financial Reporting Template”). Definitions and instructions for completing each report is included within the Exhibit L Financial Reporting Template as well as an annotation as to whether the

individual report is due Quarterly or Annually and the respective due dates. Contractor shall submit the Quarterly Financial Reports to OHA through OHA’s secure file transfer protocol (SFTP) site or other report delivery mechanism as specified by OHA.

### **3. Assumption of Risk/Private Market Reinsurance**

- a.** Contractor assumes the risk for providing the Covered Services required under this Contract. Contractor shall obtain risk protection in the form of stop-loss or reinsurance coverage against catastrophic and unexpected expenses related to Covered Services to Members.
- (1)** The method of protection may include the purchase of catastrophic expense stop-loss coverage or re-insurance by an entity authorized to insure or to reinsure in this State not inconsistent with ORS Ch. 731, and shall be documented within 30 days of signing this Contract.
  - (2)** Contractor shall not enter into a reinsurance agreement with a duration longer than one calendar year unless the agreement can be terminated at the end of a calendar year at the request of the Contractor.
  - (3)** Contractor agrees to enter into a reinsurance agreement with OHA if a statewide reinsurance program is created by the state.
  - (4)** Contractor shall notify OHA of any change in its stop-loss or reinsurance coverage within 30 days of such change.
  - (5)** Contractor understands and agrees that in no circumstances will a Member be held liable for any payments for any of the following:
    - (a)** The Contractor’s or Subcontractors’ debt due to Contractor’s or Subcontractors’ insolvency;
    - (b)** Covered Services authorized or required to be provided under this Contract to the Member, for which:
      - i.** The State does not pay the Contractor; or
      - ii.** The Contractor does not pay a Provider or Subcontractor that furnishes the services under a contractual, referral, or other arrangement; or
      - iii.** Payments for Covered Services furnished under a contract, referral or other arrangement with contractors, to the extent that those payments are in excess of the amount that the Member would owe if the Contractor provided the services directly.
  - (6)** Nothing in this Section 3., limits Contractor, OHA, a Provider or Subcontractor from pursuing other legal remedies that will not result in Member personal liability for such payments.

### **4. Restricted Reserve and Financial Solvency Requirement**

- a.** Contractor shall 1) establish a Restricted Reserve Account; and 2) maintain adequate funds in this account to meet OHA’s Primary and Secondary Restricted Reserve requirements. Reserve funds are held for the primary purpose of making payments to Providers in the event of the Contractor’s insolvency but may also be used by OHA for other obligations of Contractor in a close-out after termination of the Contract. The reserves required by this Contract cover only Covered Services provided by Contractor notwithstanding Restricted Reserve amounts required

to be maintained pursuant to separate contracts with the DHS. See OAR 410-141-3355 for the requirements for the restricted reserve.

- b. Contractors shall maintain a minimum Risk-Based Capital percentage as defined and required in OAR 410-141-3360.

- c. **Restricted Reserve Adequacy**

**Appeal Process:**

- (1) If at any time, OHA believes that Contractor has inadequate funds in its Restricted Reserve account, or that Contractor's Risk-Based Capital percentage as defined in OAR 410-141-3360, does not meet the requirements in OAR 410-141-3360, OHA will notify Contractor in writing.
- (2) Within 30 days of any notice by OHA under this Section, Contractor shall either:
  - (a) Adjust its Restricted Reserve account balance to the amount specified by OHA and provide documentation in support thereof; and, if required, develop and submit to OHA a written action plan as outlined in OAR 410-141-3360; or
  - (b) 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 45 days of the Receipt of the Appeal. That decision shall be binding upon Contractor and not subject to further appeal.

- d. **Qualified Directed Payment to Hospitals**

Contractor shall make qualified directed payments to DRG hospitals for the amounts indicated in a monthly report created by OHA to assist Contractors in distributing Quality and Access funds to the appropriate hospital. Contractor shall submit electronic payment to an account established by the hospital within five business days after receipt of the monthly report. If an error is identified in the monthly report, the Contractor shall make the payment based on the original amount provided in the report. OHA will identify separately the correction in the following month's report and adjust the total payment amount to account for the error.

- e. **Sustainable Rate of Growth Requirement**

- (1) Contractor shall manage its business operations so as to achieve sustainable growth targets. Contractor shall develop growth strategies and targets for each of its major categories of expenditure.
- (2) Contractor shall annually file a report explaining the respects in which its growth exceeded or met its growth targets with the Exhibit L. If Contractor does not achieve the sustainable growth target, OHA will issue a corrective action plan that may include financial penalties.

## Exhibit M-Behavioral Health

Behavioral Health services administered through this contract must be designed to empower Members to live, work, and thrive in their communities. Contractor shall administer services, programs, and activities in the most integrated setting appropriate to the needs of its Members consistent with Title II Integration Mandate of the Americans with Disabilities Act and the 1999 *Olmstead* decision ([https://www.ada.gov/olmstead/olmstead\\_about.htm](https://www.ada.gov/olmstead/olmstead_about.htm)).

### 1. Contractor Responsibilities

- a. Contractor shall provide Behavioral Health services in a manner designed to:
  - (1) Improve the transition of Members into integrated settings from higher levels of care;
  - (2) Increase the number of Members who are supported in the community; and
  - (3) Expand services and supports that enable Members to live successfully integrated into the community and avoid incarceration and unnecessary hospitalization.
- b. Contractor retains responsibility for providing Behavioral Health covered services and for providing care coordination for Members accessing non-covered behavioral health services listed in Exhibit B, Part 2.
- c. Contractor shall not fully delegate the provision of Behavioral Health services and care coordination to another entity.
- d. Contractor shall integrate funding at all levels of the Contractor's delivery system.
- e. Contractor shall provide covered services within the global budget (as defined in ORS 414.025) in a fully integrated manner.
- f. Contractor shall not separate funding for Behavioral Health and physical health care by fully delegating the responsibility for care coordination to another entity.
- g. Contractor may enter into value based payment arrangements for quality and efficiency so long as those arrangements do not separate the performance metrics for physical and Behavioral Health services. No value based payment arrangement or any other payment methodology is permitted that reduces the Contractor's responsibility to meet the contractual requirements for care coordination and meet each individual Member's needs for services.
- h. Contractor shall ensure the availability of service, supports or appropriate alternatives 24 hours a day/7 days a week to remediate a Behavioral Health crisis in a non-emergency department setting.
- i. Contractor shall review data and reports annually to assess whether its expenditures on Behavioral Health services are appropriate. Assessment should include review of EQRO reports, guidance from OHA, adherence to network adequacy and access standards such as member wait time to appointment and travel time and distance to providers, complaints, grievances, appeals, and any other source of information for evaluating the sufficiency of Behavioral Health access for its members.
- j. Contractor shall correct any identified deficiency in adequacy or access in a timely manner. Failure to fully remedy any deficiencies may result in corrective action or sanction pursuant to Exhibit B of this Contract.

## 2. Covered Services

### a. Access to Services

- (1) Contractor shall ensure the provision of cost-effective, comprehensive, person-centered, culturally responsive, and integrated community-based Behavioral Health services for Members.
- (2) Contractor shall ensure Members have timely access to all Behavioral Health services
- (3) Contractor shall not establish a maximum financial benefit amount for Behavioral Health services available to a Member.
- (4) Contractor shall establish written policies and procedures for Behavioral Health covered services.
  - (a) Contractor shall provide the written policies and procedures to OHA by the beginning of CY 2020.
  - (b) Policies and procedures must address, at a minimum, administration of the benefit, which services have prior authorizations, and a description of the provider network, including the number of providers for each service.
- (5) Contractor shall ensure Members have access to behavioral health screenings and referrals for treatment at multiple health system or health care entry points.
- (6) Contractor shall reimburse for covered Behavioral Health services rendered in a primary care setting by a qualified Behavioral Health provider, and shall reimburse for covered physical health services in Behavioral Health care settings, by a qualified medical provider.
- (7) Contractor shall ensure Members receive services from Non-Participating Providers for Behavioral Health services if those services are not available from Participating Providers or if a Member is not able to access services within the timely access to care standards.
  - (a) Contractor shall remain responsible for coordinating Behavioral Health services with Non-Participating Providers and reimbursing for services.
  - (b) Contractor may cover and reimburse inpatient psychiatric services, not including substance use disorder treatment, at an Institution for Mental Diseases, as defined in 42 §CFR 435.1010, provided:
    - i. The facility is a hospital providing inpatient psychiatric services; and
    - ii. The length of stay is no more than 15 days during the period of the monthly Capitation Payment. The provision of inpatient psychiatric treatment in an IMD must meet the requirements for in lieu of services at 42 CFR §438.3(e)(2)(i) through (iii). Contractor must offer the Member the option to access the state plan services in accordance with OAR 410-141-3160 (10).

### b. Assessments and Screening

- (1) Contractor shall use a standardized behavioral health assessment tool, approved by OHA, to assist in adapting the intensity and frequency of Behavioral Health services to the Behavioral Health needs of the Member

- (2) Contractor shall require providers to screen Members for adequacy of supports for the family in the home (e.g., housing adequacy, nutrition/food, diaper needs, transportation needs, safety needs and home visiting).
- (3) Contractor shall ensure screening for all Members and provide prevention, early detection, brief intervention and referral to Substance Use Disorders treatment who are in any of the following circumstances:
  - (a) At an initial contact or during a routine physical exam;
  - (b) At an initial prenatal exam;
  - (c) When the Member shows evidence of Substance Use Disorders or abuse (as noted in the OHA approved screening tools);
  - (d) When the Member over-utilizes Covered Services;
  - (e) When a Member exhibits a reassessment trigger for Intensive Care Coordination needs.

**c. Substance Use Disorders Treatment**

- (1) Contractor shall provide Substance Use Disorders (SUD) services to Members, which includes outpatient, intensive outpatient, medication assisted treatment including, Opiate Substitution Services, residential and detoxification treatment services consistent with OAR Chapter 309, Divisions 18, 19 and 22, Chapter 415 Division 20, and OAR Chapter 415 Division 50.
- (2) Contractor shall inform all Members using culturally responsive and linguistically appropriate means that Substance Use Disorders outpatient, intensive outpatient, residential, detoxification and medication assisted treatment services, including opiate substitution treatment, are covered services consistent with OAR 410-141-3300.
- (3) Contractor shall provide Members with culturally responsive and linguistically appropriate alcohol, tobacco, and other drug abuse prevention/education that reduces Substance Use Disorders risk to Members. Contractor's prevention program shall meet or model national quality assurance standards. Contractor shall have mechanisms to monitor the use of its preventive programs and assess their effectiveness on its Members.
- (4) Contractor shall provide covered culturally responsive and linguistically appropriate Substance Use Disorders services for any Member who meets ASAM placement criteria for:
  - (a) Outpatient, intensive outpatient, residential, detoxification and medication assisted treatment including opiate substitution treatment, regardless of prior alcohol/other drug treatment or education.
  - (b) Specialized programs in each Service Area in the following categories: drug court referrals, Child Welfare referrals, Job Opportunities and Basic Skills (JOBS) referrals, and referrals for persons with co-occurring disorders.
- (5) Contractor shall consider each Member's needs and, to the extent appropriate and possible, provide specialized Substance Use Disorders services designed specifically for the following groups:
  - (a) Adolescents, taking into consideration adolescent development,
  - (b) Women, and women's specific issues,

- (c) Ethnically and racially diverse groups and environments that are culturally responsive and linguistically relevant,
  - (d) Intravenous drug users,
  - (e) Individuals involved with the criminal justice system,
  - (f) Individuals with co-occurring disorders,
  - (g) Parents accessing residential treatment with any accompanying dependent children, and
  - (h) Individuals accessing residential treatment with medication assisted therapy.
- (6) Contractor shall, where Medically Appropriate, provide detoxification in a non-hospital facility. Facilities or programs providing detoxification services must have a letter of approval or license from OHA.
- (7) Contractor shall authorize and pay for culturally responsive and linguistically appropriate outpatient Substance Use Disorders services to eligible Members who meet ASAM PPC-2R criteria for residential treatment services, when residential treatment services are not immediately available.
- (8) Contractor's employees or providers providing Substance Use Disorders services shall provide to Member, to the extent of available community resources and as clinically indicated, information and referral to community services which may include, but are not limited to: child care, elder care, housing, transportation, employment, vocational training, educational services, mental health services, financial services, and legal services.
- (9) In addition to any other confidentiality requirements described in this Contract, Contractor shall follow the federal (42 CFR Part 2) confidentiality laws and regulations governing the identity and medical/Client records of Members who receive Substance Use Disorders services.

**d. Assertive Community Treatment (ACT)**

- (1) Contractor shall require that a provider or care coordinator meets with the Member face-to-face to discuss ACT services and provide information to support the Member in making an informed decision regarding participation. This must include a description of ACT services and how to access them, an explanation of the role of the ACT team and how supports can be individualized based on the Member's self-identified needs, and ways that ACT can enhance a Member's care and support independent community living.
- (2) Contractor shall be responsible for engaging with all eligible Members who decline to participate in ACT in an attempt to identify and overcome barriers to the Member's participation.
- (3) Contractor shall document efforts to provide ACT to individuals who initially refuse ACT services, and shall document all efforts to accommodate their concerns.
- (4) Contractor shall offer alternative evidence-based intensive services for individuals discharged from OSH who refuse ACT services.
- (5) Contractor shall provide alternative evidence-based intensive services if Member continues to decline participation in ACT, which must include coordination with an ICC.

- (6) Contractor shall ensure that:
  - (a) Members with SPMI are assessed to determine eligibility for ACT.
  - (b) ACT services are provided for all adult Members with SPMI who are referred to and eligible for ACT services in accordance with OAR 309-019-0105 and 309-019-0225 through 309-019-0255.
  - (c) Additional ACT capacity is created to serve adult Members with SPMI as services are needed.
- (7) When ten (10) or more of Contractor's adult Members with SPMI in Contractor's Service Area are on a waitlist to receive ACT for more than thirty (30) days, without limiting other Contractor solutions, additional capacity shall be created by either increasing existing ACT team capacity to a size that is still consistent with Fidelity standards or by adding additional ACT teams.
- (8) If Contractor lacks qualified providers to provide ACT services, Contractor shall consult with OHA and develop a plan to develop additional qualified providers. Lack of capacity shall not be a reason to allow individuals who are determined to be eligible for ACT to remain on the waitlist. No individual on a waitlist for ACT services should be without such services for more than 30 days.
- (9) Contractor shall ensure all denials of ACT services for all adult Members with SPMI are:
  - (a) Based on established, evidence-based medical necessity criteria;
  - (b) Recorded and compiled in a manner that allows denials to be accurately reported out as appropriate or inappropriate;
  - (c) Follow the Notice of Adverse Benefit Determination process for all denials as described in Exhibit B, XX.
- (10) For Members who have appropriately received a denial for a particular ACT team but who meet ACT eligibility standards, Contractor shall be responsible for finding or creating a team to serve the Member.
- (11) Contractor shall report number of individuals referred to ACT, number of individuals admitted to ACT programs, number of denials for the ACT benefit, number of denials to ACT programs, and number of individuals on waitlist by month.
- (12) Contractor shall ensure a Member discharged from OSH who is appropriate for ACT shall receive ACT or an evidence-based alternative.
- (13) Contractor shall ensure a Member discharged from OSH who is determined not to meet the level of care for ACT shall be discharged with services appropriate to meet their needs.

**e. Peer Delivered Services**

- (1) Contractor shall encourage utilization of Peer Delivered Services (PDS) and ensure that Members are informed of their benefit to access and receive PDS from a Peer Support Specialist, Peer Wellness Specialist, Family Support Specialist, or Youth Support Specialist as applicable to the Member's diagnosis and needs.
- (2) Information provided must include a description of Peer Delivered Services and how to access it, a description of the types of PDS providers, an explanation of the role of the PDS provider, and ways that PDS can enhance a Member's care.

- (3) Contractor shall provide access to Peer-Delivered Services for each Member seeking these services consistent with OAR 309-019-0105.
- (4) Contractor may utilize Peer-Delivered Services in providing other Behavioral Health services such as ACT, Crisis services, Warm Handoffs from hospitals, and services at Oregon State Hospital.

**f. Supported Employment**

- (1) Contractor shall ensure access to supported employment services for all adult Members eligible for these services, in accordance with OAR 309-019-0275 through 309-019-0295.
- (2) Contractor shall report number of individuals referred to Supported Employment (SE), number of individuals receiving SE, number of individuals receiving SE that are employed in Competitive Integrated Employment.

**g. Crisis, Urgent, and Emergency Services**

- (1) Contractor shall establish written policies and procedures and monitoring systems for an emergency response system, including post-stabilization care services and Urgent Services for all Members on a 24-hour, 7-day-a-week basis consistent with OAR 410-141-3140 and 42 CFR 438.114. The emergency response system must provide an immediate, initial or limited duration response for emergency situations or potential Behavioral Health emergency situations that may include Behavioral Health conditions, including:
  - (a) Screening to determine the nature of the situation and the Member's immediate need for Covered Services;
  - (b) Capacity to conduct the elements of a Behavioral Health Assessment that are needed to determine the interventions necessary to begin stabilizing the crisis situation;
  - (c) Development of a written initial services plan at the conclusion of the Behavioral Health Assessment;
  - (d) Provision of Covered Services and outreach needed to address the urgent or emergency situation; and
  - (e) Linkage with the public sector crisis services, such as pre-commitment.
- (2) Contractor shall ensure access to Mobile Crisis Services for all Members in accordance with OAR 309-019-0105, OAR 309-019-0150, 309-019-0242, 309-019-0243 and 309-019-0300 to 309-019-0320 to promote stabilization in a community setting rather than arrest, presentation to an emergency department, or admission to an acute psychiatric care facility.
- (3) Contractor shall establish written policies and procedures for a quality improvement plan for the emergency response system.
- (4) The emergency response system must include the necessary array of services to respond to mental health crises, that may include crisis hotline, mobile crisis team, walk-in/drop-off crisis center, crisis apartment/respite and short-term stabilization unit capabilities.
- (5) Contractor shall establish written policies and procedures and monitoring system for an emergency response system. The emergency response system must provide an

immediate, initial or limited duration response for potential mental health emergency situations or emergency situations that may include mental health conditions, including:

- (a) Screening to determine the nature of the situation and the person’s immediate need for Covered Services;
- (b) Capacity to conduct the elements of a Mental Health Assessment that are needed to determine the interventions necessary to begin stabilizing the crisis situation;
- (c) Development of a written initial services plan at the conclusion of the Mental Health Assessment;
- (d) Provision of Covered Services and Outreach needed to address the urgent or emergency situation; and
- (e) Linkage with the public sector crisis services, such as pre-commitment.

**h. Non-covered Services**

- (1) Consistent with Exhibit B, Part 2, Section 6, Non-Covered Services with Care Coordination, Contractor shall coordinate referral and follow-up of Members to Non-Covered Services.
- (2) Contractor shall provide non-health related services, supports and activities that can be expected to improve a Member’s Behavioral Health condition including flexible funding as defined by the SOCWI guidance document link found in Exhibit B, part 2(4)(m)(1).

**i. Prior Authorization**

- (1) Notwithstanding the requirements outlined in Exhibit B Part 2, Contractor shall establish written procedures that Contractor follows, and requires Participating Providers and Subcontractors to follow, for the initial and continuing Service Authorization Requests. The procedures must require that any decision to deny a Service Authorization Request or to authorize a service in an amount, duration or scope that is less than requested, be made by a Health Care Professional who has appropriate clinical expertise in treating the Member’s physical, behavioral or oral health condition or disease in accordance with 42 CFR §438.210.
- (2) Contractor shall establish written policies and procedures for prior authorizations that are compliant with Mental Health Parity regulations in 42 CFR part 438, subpart K.
- (3) Contractor shall monitor prior authorizations and must report an accurate number of approvals and denials to OHA, upon request.
- (4) Contractor shall not require prior authorization for outpatient Behavioral Health services or Behavioral Health peer delivered services.
- (5) Any non-emergent prior authorization for hospitalization and residential care shall be approved within three days for children, youth or adult members.
- (6) The prior authorization for any service and the length of any prior authorization shall be based on an evidence-based standard of medical necessity.
- (7) Prior authorized services shall be reviewed for consistency of medical necessity application, using a standardized methodology such as inter-rater reliability, with a concordance rate that is equal to or more favorable than the standard applied to medical/surgical services.

- (8)** Denials of prior authorized services shall be made by a professional peer, a person with the clinical scope of practice to order the service being requested.
- (9)** Contractor shall also ensure that any treatment limitations placed on Medically Necessary Covered Services are no more restrictive than those applied to fee-for-service medically necessary covered benefits, as described in 42 CFR 438.210(a)(5)(i).
- (10)** Contractor may require Members and Subcontractors to obtain authorization for Covered Services from Contractor, except to the extent Prior Authorization is prohibited by OHP rules or elsewhere in this Contract.
- (11)** Contractor may not require Members to obtain the approval of a Primary Care Physician in order to gain access to behavioral health Assessment and Evaluation services. Members may refer themselves to behavioral health services available from the Provider Network.
- (12)** Contractor shall have in effect mechanisms to ensure consistent application of review criteria for authorization decisions, taking into account applicable clinical practice guidelines, and consults with the requesting Provider when appropriate.
- (13)** For standard Service Authorization Requests, Contractor shall provide notice to the requesting provider as expeditiously as the Member's health or behavioral health condition requires, not to exceed 14 days following receipt of the request for service, with a possible extension of 14 additional days if the Member or Provider requests extension, or if the Contractor justifies a need for additional information and how the extension is in the Member's interest.
- (14)** If Contractor extends the time frame, Contractor shall provide the Member and Provider with a written notice of the reason for the decision to extend the timeframe and inform the Member of the right to file a Grievance if he or she disagrees with that decision. When a decision is not reached regarding a Service Authorization Request within the timeframes specified above, or if an CCO denies a service authorization request, or decides to authorize a service in an amount, duration, or scope that is less than requested, the Contractor shall issue a notice of adverse benefit determination to the Provider and Member, or Member Representative, consistent with Exhibit I, Grievance System.
- (15)** If a Member or Provider suggests, or Contractor determines, that following the standard timeframes could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function, Contractor shall make an expedited service authorization decision, and provide Notice, as expeditiously as the member's health or behavioral health condition requires and no later than 72 hours after receipt of the request for service. Contractor may extend the 72 hour time period by up to 14 days if the Member requests an extension, or if Contractor justifies a need for additional information and how the extension is in the Member's interest.
- (16)** Contractor shall notify the requesting Provider, in writing or orally, when Contractor denies a request to authorize a Covered Service or when the Service Authorization Request is in an amount, duration, or scope that is less than requested.
- (17)** Contractor shall notify the Member in writing of any decision to deny a Service Authorization Request, or to authorize a service in an amount, duration or scope that is less than requested pursuant to the requirements of Exhibit I.

### **3. Care Coordination and Integration**

#### **a. Care Coordination**

- (1)** Contractor shall provide Care Coordination for Members with Behavioral Health disorders in accordance with Exhibit B in this Contract.
- (2)** Contractor shall ensure all care coordinators work with team members to coordinate integrated care. This includes coordination of: physical health, behavioral health, intellectual and developmental disability, DHS, OYA, social determinants of health and ancillary services.
- (3)** Contractor must abide by OAR410-141-3160/3170 in regards to care integration and interdisciplinary team requirements for members receiving ICC.
- (4)** Contractor shall ensure sufficient resources, including technological, financial, provider and workforce, to integrate Behavioral Health services with oral and physical health care.
- (5)** Contractor shall provide oversight, care coordination, transition planning and management of the Behavioral Health needs of Members to ensure culturally responsive and linguistically appropriate Behavioral Health services are provided in a way that Members are served in the most natural and integrated environment possible and that minimizes the use of institutional care. Contractor shall follow ICC standards as identified in OAR 410-141-3160/3170.
- (6)** Contractor shall enter into a written memorandum of understanding (MOU) with the local community mental health program (CMHP) in Contractor's service area by January 1, 2020.

The MOU shall include:

- (a)** A formalized agreement that the Contractor will coordinate with the CMHP on the development of a comprehensive Behavioral Health Plan for Contractor's service area; and
  - (b)** All the requirements identified in ORS 414.153.
- (7)** Contractor shall develop a comprehensive Behavioral Health plan for Contractor's service area in collaboration with the local mental health authority and other community partners (e.g., education/schools, hospitals, corrections, police, first responders, child welfare, DHS, public health, peers, families, housing authorities, housing providers, courts).
  - (8)** Contractor shall ensure that periodic social-emotional screening for all children birth through five years is conducted in the primary care setting and shall have a process in place to address any concerns revealed by the screening in a timely manner.
  - (9)** Contractor shall support providers in screening all (universal screening) pregnant women for behavioral health needs (mental health and substance use), at least once during pregnancy and post-partum. Contractor shall ensure medically appropriate follow-up and referral as indicated by screening. Contractor shall ensure and provide timely appropriate referrals, and follow-up to referrals for pregnant and post-partum women.
  - (10)** Contractor shall ensure that clinical staff providing post-partum care is prepared to refer patients to appropriate behavioral health resources when indicated and that systems are in place to ensure follow-up for diagnosis and treatment

- (11) Contractor shall execute the work and milestones outlined in Contractor's MOU with the CMHP.
- (12) Contractor shall work collaboratively with OHA and CMHPs to develop and implement plans to better meet the needs of Members in less institutional community settings and to reduce recidivism to emergency departments for Behavioral Health reasons.
- (13) Contractor shall work collaboratively with other providers in the health care continuum to improve services for adult Members with SPMI.
- (14) Contractor shall coordinate and collaborate on the development of the community health improvement plan (CHP) under ORS 414.627 with the local community mental health program (CMHP) for the delivery of mental health services under ORS 430.630.
- (15) Contractor shall work with SRTFs to expeditiously move civilly committed adult Members with SPMI who no longer need placement in an SRTF to a community placement in the most integrated setting appropriate for that person. Discharge shall be to housing consistent with the individual's treatment goals, clinical needs, and the individual's informed choice. The individual's geographic preferences and housing preferences (e.g., living alone or with roommates) shall be reasonably accommodated in light of cost, availability, and the other factors stated above.
- (16) Contractor shall work with local law enforcement and jail staff to develop strategies to reduce contacts between Members and law enforcement due to Behavioral Health reasons, including reduction in arrests, jail admissions, lengths of stay in jails and recidivism.
- (17) Contractor will work with local jurisdictions to share information with jails regarding the Behavioral Health diagnosis, status, medication regimen, and services of Members who are incarcerated.

**b. Oregon State Hospital**

- (1) Contractor will assume increasing accountability for Members who are civilly committed and are referred to and enter Oregon State Hospital.
- (2) Contractor will be financially responsible for Members on the waitlist for Oregon State Hospital after Contract Year 2021, with a timeline to be determined by OHA.
- (3) Contractors will be financially responsible and begin to share risk for services for Members in OSH after contract year 2021, with a timeline to be determined by OHA.
- (4) Contractor shall, in accordance with OAR 309-091-0000 through 0050:
  - (a) Coordinate with applicable subcontractors as needed regarding Oregon State Hospital discharges for all adult Members with SPMI;
  - (b) Coordinate care for members receiving behavioral health treatment while admitted to the State hospital during discharge planning for the return to Home CCO or to the receiving CCO if the Member will be discharging into a different CCO when the patient has been deemed ready to transition;
  - (c) Arrange for both physical and behavioral health care services coordination;
  - (d) Provide case management, care coordination and discharge planning for timely follow up to ensure continuity of care;

- (e) Coordinate with OHA regarding members who are presumptively or will be retroactively enrolled upon discharge;
  - (f) Arrange for all services to be provided post-discharge in a timely manner; and
  - (g) Provide access to evidence-based intensive services for adult Members with SPMI discharged from Oregon State Hospital who refuse ACT services.
- (5) Discharges from OSH shall not be to a secure residential treatment facility unless clinically necessary. No one shall be discharged to a secure residential treatment facility without the express approval of the Director of OHA or his/her designee.

**c. Emergency Department Utilization**

- (1) Contractor shall establish a policy and procedure for the development and implementation of a management plan for contacting and offering services to each Member who has two (2) or more readmissions to an Emergency Department in a six-month period. The management plan will address the following key areas:
- (a) Reduce admissions to emergency departments.
  - (b) Reduce readmissions to emergency departments.
  - (c) Reduce the length of time Members spend in emergency departments.
  - (d) Ensure Members with SPMI have appropriate connection to community-based services after leaving an emergency department and will have a follow-up visit from Intensive Care Coordinator or other relevant provider within 3 (three) days.
- (2) Contractor shall work with hospitals to provide data on Emergency Department (ED) utilization for Behavioral Health reasons and length of time in the ED. Contractor shall develop remediation plans with EDs with significant numbers of ED stays longer than 23 hours.
- (3) Contractor shall work with hospitals on strategies to reduce ED utilization by Members with Behavioral Health disorders.

**d. Involuntary Psychiatric Care**

- (1) Contractor shall make a reasonable effort to provide Covered Services on a voluntary basis and consistent with current Declaration for Mental Health Treatment as provided at: <http://www.oregon.gov/oha/amh/forms/declaration.pdf> in lieu of involuntary treatment.
- (2) Contractor shall establish written policies and procedures describing the appropriate use of Emergency Psychiatric Holds consistent with ORS 426 and alternatives to involuntary psychiatric care when a less restrictive voluntary service will not meet the Medically Appropriate needs of the Member and the behavior of the Member meets legal standards for the use of an Emergency Psychiatric Hold.
- (3) Contractor shall only use psychiatric inpatient facilities and non-inpatient facilities certified by OHA under OAR 309-033-0200 through 309-033-0340.
- (4) Contractor shall comply with ORS Chapter 426 and OAR 309-091-0000 through 0050 for involuntary Civil Commitment of those Members who are civilly committed under ORS 426.130.
- (5) Contractor shall ensure that any involuntary treatment provided under this Contract is provided in accordance with administrative rule and statute and shall coordinate with the

CMHP Director in assuring that all statutory requirements are met. Contractor shall work with the CMHP Director in assigning a civilly committed Member to any placement and participate in circuit court hearings related to planned placements, if applicable.

**e. Long Term Psychiatric Care (LTPC)**

**(1) For a Member age 18 or older:**

- (a)** If Contractor identifies a Member, age 18 to age 64, with no significant nursing care needs due to a general medical condition, acute medical condition or physical disorder of an enduring nature, is appropriate for LTPC, Contractor shall request a LTPC determination from the applicable HSD Adult Mental Health Services Unit, as described in Procedure for LTPC Determinations for Members 18 to 64, available on the Contract Reports Web Site.
  - i.** HSD Adult Mental Health Services Unit will respond to Contractor no more than three Business Days following the date HSD receives a completed Request for LTPC Determination for Member 18-64.
- (b)** If Contractor identifies a Member, age 65 and over, or age 18 to age 64 with significant nursing care needs due to a general medical condition, acute medical condition or physical disorder of an enduring nature, is appropriate for LTPC, Contractor shall request a LTPC determination from the State hospital-NTS, Outreach and Consultation Service (OCS) Team as described in Procedure for LTPC Determinations for Member Requiring Neuropsychiatric Treatment, available on the Contract Reports Web Site.
  - i.** OCS Team will respond to Contractor no more than three Business Days following the date the OCS Team receives a completed Request for LTPC Determination for Member Requiring Neuropsychiatric Treatment.
- (c)** A Member is appropriate for LTPC when the Member needs either Intensive Psychiatric Rehabilitation or other tertiary treatment in a State Facility or extended care program or extended and specialized medication adjustment in a secure or otherwise highly supervised environment; and the Member has received all usual and customary treatment, including, if Medically Appropriate, establishment of a Medication Management Program and use of a Medication Override Procedure.
- (d)** OHA will cover the cost of LTPC of Members age 18 to 64 determined appropriate for such care beginning on the effective date specified below and ending on the date the Member is discharged from such setting, until such time that OHA transfers this financial responsibility to Contractor.
- (e)** If a Member is ultimately determined appropriate for LTPC, the effective date of such determination is either:
  - i.** Within three Business Days of the date HSD Adult Mental Health Services Unit staff receives a completed Request for LTPC Determination for Persons Age 18 to 64;
  - ii.** The date the State Facility -NTS OCS Team receives a completed Request for LTPC Determination for Persons Requiring State hospital-NTS;
  - iii.** In cases where OHA and Contractor mutually agree on a date other than these dates, the date mutually agreed upon; or



**f. Acute Inpatient Hospital Psychiatric Care**

- (1) Contractor will be financially responsible for mental health residential benefit for Members after Contract Year 2021, with a timeline to be determined by OHA.
- (2) Contractor shall provide Acute Inpatient Hospital Psychiatric Care for Members who do not meet the criteria for LTPC and for whom it is medically indicated. Contractor shall submit required data through the Oregon Patient/Resident Care System (OPRCS).
- (3) A Medication Override Procedure is considered a “significant procedure” as defined in OAR 309-033-0610. Contractor may perform a Medication Override Procedure only after the person has been committed, there is good cause as described in OAR 309-033-0640, Involuntary Administration of Significant Procedures to a Committed Person with Good Cause, and the requirements of OAR 309-033-0640 have been met.
- (4) Contractor shall establish a policy and procedure for the development and implementation of a management plan for contacting and offering services to each Member who has two (2) or more readmissions to an Acute Care Psychiatric Hospital in a six-month period. The management plan will address subsections (5)-(10) in this section.
- (5) Contractor shall ensure all Members discharged from Acute Care Psychiatric Hospitals are provided a Warm Handoff to a community case manager, peer bridger, or other community provider prior to discharge, and that all such Warm Handoffs are documented.
- (6) Contractor shall ensure that all Members discharged from Acute Care Psychiatric Hospitals have linkages to timely, appropriate behavioral and primary health care in the community prior to discharge and that all such linkages are documented, in accordance with OAR provisions 309-032-0850 through 309-032-0870.
- (7) Contractor shall ensure all adult Members receive a follow-up visit with a community Behavioral Health provider within seven (7) days of their discharge from an Acute Care Psychiatric Hospital, or 3 days if Member is involved in Intensive Care Coordination services.
- (8) Contractor shall reduce readmissions of adult Members with SPMI to Acute Care Psychiatric Hospitals.
- (9) Contractor shall coordinate with system community partners to ensure Members who are homeless and who have had two or more readmissions to an Acute Care Psychiatric Hospital in a six-month period are connected to a housing agency or mental health agency to ensure these Members are linked to housing in an integrated setting, consistent with the individual’s treatment goals, clinical needs and the individual’s informed choice.
- (10) Contractor shall work with OHA and the CMHPs to ensure that Members who are discharged from Acute Care Psychiatric Hospitals are discharged to housing that meets the individuals’ immediate need for housing and shall work with Acute Care Psychiatric Hospitals in the development of each individual’s housing assessment. The housing assessment will be documented in a plan for integrated housing that is part of the individual’s discharge plan, and will be based on the individual’s treatment goals, clinical needs, and the individual’s informed choice. Contractor shall notify, or require the Acute Care Psychiatric Hospital to notify, the community provider to facilitate the implementation of the plan for housing.

**g. Psychiatric Residential Treatment Services and Psychiatric Day Treatment Services (PRTS / PDTS)**

- (1) Contractor shall adopt policies and guidelines for admission into Psychiatric Residential Treatment Services (PRTS), Psychiatric Day Treatment Services (PDTS) and/or intensive outpatient services and supports.
- (2) Contractor shall ensure that admission to Psychiatric Residential Treatment Services are in accordance with Certificate of Need process described in OAR-410-172-0690 and conducted through a OHA-approved independent reviewer.
- (3) Services and supports shall be authorized to meet the needs of the child or youth which address the recommendations stated in the mental health assessment.
  - (a) Referrals shall be reviewed within 3 days.
  - (b) If the referral results in a change or denial of service, a Notice of Action must be issued to the Member, in accordance with the provisions of Exhibit I.
  - (c) If Contractor denies a service, a medically appropriate plan of care shall be developed to address the Behavioral Health needs of the Member.

**h. Intensive Care Coordination**

- (1) Contractor shall authorize and reimburse care coordination services, in particular Members who receive ICC, that are sufficient in amount, duration or scope to reasonably be expected to achieve the purpose for which the services are provided to Members receiving care through licensed community treatment programs.
- (2) Contractor shall authorize and reimburse for ICC services, in accordance with standards identified in OAR 410-141-3160/3170.
- (3) Contractor shall ensure coordination and appropriate referral to Intensive Care Coordination to ensure that Member's rights are met and there is post-discharge support. If Member is connected to ICC coordinator, Contractor shall ensure coordination is in accordance with the requirements outlined in OAR 410-141-3160/3170.
- (4) Contractor shall ensure that Members with SPMI receive ICC support in finding appropriate housing and receive coordination in addressing Member's housing needs. Housing should be consistent with the individual's treatment goals, clinical needs, and the individual's informed choice. The individual's geographic preferences and housing preferences (e.g., living alone or with roommates) shall be reasonably accommodated, in light of cost, availability, and the other factors stated above. Among housing types, where available and appropriate, Supported Housing is the most integrated and preferred option.
- (5) Contractor shall ensure there are multiple rescreening points for Members based on reassessment triggers for ICC .
- (6) Contractor shall adopt policies and procedures to track and coordinate for ICC reassessment triggers.
- (7) Members who receive Intensive Care Coordination (ICC) services must have the option to have ICC support in continuity of care throughout episodes of care for all care coordination needs as identified in OAR 410-141-3160/3170.
- (8) Contractor shall arrange for the provision of non-health related services, supports and activities that can be expected to improve a Behavioral Health condition.

**i. Transition/Discharge**

- (1) Contractor shall provide oversight, care coordination, transition planning and management for Members receiving Behavioral Health services, including Mental Health Rehabilitative Services and Personal Care Services, in licensed and non-licensed home and community based settings.
- (2) Contractor shall ensure that members transitioning to another healthcare setting are placed consistent with the individual's treatment goals, clinical needs, and the individual's informed choice. Contractor shall follow ICC standards as identified in OAR 410-141-3160/3170.
- (3) Contractor shall provide Utilization Review and utilization management, for Members receiving Mental Health Rehabilitative Services and Personal Care Services in licensed and non-licensed home and community-based settings, ensuring that individuals who no longer need placement in such setting are transition to a community placement in the most integrated setting appropriate for that person.
- (4) Contractor shall ensure continuity of care at all times, over all episodes and levels of care.
- (5) The intensive care coordinator assigned by the Contractor shall have contact with active program-specific care team(s), at least twice per month for general coordination, or sooner if clinically necessary for Member's care.
- (6) Contractor shall maintain responsibility for providing Behavioral Health services if a Member needs services which are out of the Contractor's service area due to lack of local availability.
- (7) The intensive care coordinator shall work with any provider to ensure a smooth transition between service areas and episodes of care.
- (8) The assigned intensive care coordinator shall participate and play an active role in discharge planning for Member.
  - (a) The care coordinator shall have contact with the Member no less than 2 times per month prior to discharge and 2 times within the week of discharge.
  - (b) Contractor shall ensure a face-to-face Warm Handoff for Member between any care coordinator and other relevant care provider during transition of care and discharge planning.
  - (c) Care coordinators (including ICC, if appropriate) shall also engage with the Member, face to face, within 3 days post discharge.
  - (d) Contractor shall require a transition meeting and development of a transition plan that includes a description of how treatment and supports will continue. This meeting shall be held 30 days prior to discharge or as soon as possible, no later than within one week of discharge, if notified of impending transition with less than 30 days lead time.
  - (e) Contractor shall require a post-transition meeting of Interdisciplinary Team for members requiring ICC, within 14 days, to ensure care was continued and quickly address any gaps.
  - (f) Contractor shall ensure members maintain access to appropriate services continue after discharge.

- (9) Contractor shall report on the number of Warm Handoffs that occur.

#### **4. Children and Youth Behavioral Health Services**

##### **a. Provision of Services**

- (1) Contractor shall provide services to children, young adults and families of sufficient frequency, duration, location, and type that are convenient to the youth and family. Services should be expected to alleviate crisis while allowing for the development of natural supports, skill development, normative activities and therapeutic resolution to Behavioral Health disorders and environmental conditions that may impact the remediation of a Behavioral Health disorder.
- (2) Contractor shall maintain an intensive and flexible service continuum for children and youth who are at risk of placement disruption, school failure, criminal involvement, homelessness or other undesirable outcomes due a Behavioral Health disorder.
- (3) Children and youth shall not be required to participate in Wraparound services in order to access Intensive Treatment Services (ITS) or Intensive Care Coordination (ICC).
- (4) Contractor shall utilize evidence-based Behavioral Health interventions for the behavioral health needs of members who are children and youth.
- (5) Contractor shall ensure Members have access to evidence-based dyadic treatment and treatment that allows children to remain living with their primary parent or guardian.
- (6) Contractor shall provide care coordination or Intensive Care Coordination (ICC), as appropriate, that is family and youth-driven, strengths based, culturally responsive and linguistically appropriate.
- (7) Contractor shall ensure ICC is provided, at a minimum, for Members 17 and younger for any of the following situations, or any other population entitled to ICC services in accordance with OAR 410-141-3160/3170:
  - (a) Children and youth engaged in Behavioral Health services that have two or more placement disruptions due to emotional and/or behavioral precipitators in less than one year.
  - (b) Children and youth placed in a correctional facility solely for the purpose of stabilizing a Behavioral Health condition.
  - (c) Children and youth placed out of the Contractor's service area in Behavior Rehabilitation Services programs under the jurisdiction of child welfare.
  - (d) Children and youth, known to be receiving or to have received care in an Emergency Department, or admission to Acute Inpatient Psychiatric Care and/or Sub-Acute Care or upon discharge from such care
- (8) Contractor shall coordinate admissions to and discharges from Acute Inpatient Hospital Psychiatric Care and Sub-Acute Care for Members 17 and under, including Members in the care and custody of DHS Child Welfare or OYA. For a Member 17 and under, placed by DHS Child Welfare through a Voluntary Placement Agreement (CF 0499), Contractor shall also coordinate with such Member's parent or legal guardian.

**b. Wraparound Services**

- (1) Contractor shall complete a plan for serving eligible youth in Wraparound so that no youth is placed on a waitlist. This strategy shall ensure there is no waitlist for youth who meet criteria. This strategy shall ensure that contractor has the ability to implement Wraparound to fidelity.
- (2) Contractor shall ensure that Wraparound services and supports include Family Support Specialist, (Family Partners) and Young Adult Support Specialists (Youth Partners), as appropriate.
- (3) Contractor shall ensure that Family Support Specialists and Young Adult Support Specialists have experience navigating the Behavioral Health, child welfare, or juvenile justice system with a child or youth, and be active participants in the Wraparound process, and that family support specialists engage and collaborate with systems alongside the family, parent, or guardian. Contractor shall refer to the System of Care guidance document in Exhibit B Part 2 on expectations for Family Support Specialists and Young Adult Support Specialists.
- (4) Contractor shall establish and maintain a Wraparound policy which includes:
  - (a) The services and supports a Child and Family Team can select and which services and supports need prior approval of the Providers; and
  - (b) The process required for the Child and Family Team to obtain approval from the Contractor/Subcontractor for services and supports that need approval.
- (5) Contractor shall submit revisions to the Wraparound policy annually to OHA, no later than January 31, that have been approved by its System of Care Executive Council, to the OHA Contract Administration Unit for review and approval. OHA will notify Contractor within 30 days of the approval status of the policy. Subsequent submissions will be upon OHA request.
- (6) Contractor shall maintain sufficient funding and resources to implement Wraparound Care Coordination Services to fidelity for Members 17 years and younger for any of the following situations:
  - (a) Placement in Secure Adolescent Inpatient Program (SAIP), Secure Children’s Inpatient Program (SCIP);
  - (b) Psychiatric Residential Treatment Services (PRTS) or the Commercial Sexually Exploited Children’s residential program funded by OHA; and
  - (c) Children meeting local/regional Wraparound Initiative entry criteria.
- (7) Contractor shall enroll all eligible youth in Wraparound and place no youth on a waitlist.
- (8) Contractor shall ensure that core values and principles described in ORS 418.977 are followed in delivering Wraparound services and supports, Wraparound Care Coordination and Team Facilitation.
- (9) Contractor shall ensure that every youth in Wraparound receives a Child and Adolescent Needs and Strengths (CANS) screening within 30 days of enrollment and every 90 days thereafter.

- (10) For Wraparound services, Contractor shall ensure that the ratio of care coordinators, family support specialists, and youth support specialists to families served is no greater than 1:15.
- (11) Upon discharge from a Wraparound program, Contractor shall ensure that Member is re-screened and assessed for Intensive Care Coordination needs, as identified in OAR 410-141-3160-70.

**c. Wraparound Review Committee**

- (1) Contractor shall convene and maintain a Wraparound Review Committee which shall review all referrals submitted to the Wraparound program and determine eligibility for entry into the program.
- (2) Contractor shall submit any consistently identified Wraparound or system barriers to the System of Care Practice Level Workgroup up through the Executive Council if needed and submit barriers that remain unresolved to the State System of Care Steering Committee. These workgroups and councils are further defined in the contract under the System of Care, in 6. Of this section.
- (3) Contractor shall screen all eligible youth with a Wraparound Review Committee in accordance with Wraparound Services as described in the OHA System of Care Wraparound Initiative (SOCWI) guidance document found at: <http://www.oregon.gov/oha/hsd/amh/pages/index.aspx>.
- (4) Contractor shall ensure the implementation of fidelity Wraparound by hiring and ensuring that each role is trained in Fidelity Wraparound.
- (5) Contractor shall hire and train the following staff:
  - (a) Wraparound Care Coordinator;
  - (b) Wraparound Supervisor;
  - (c) Wraparound Coach;
  - (d) Youth Peer Delivered Service Provider;
  - (e) Family Peer Delivered Service Provider; and
  - (f) Peer Delivered Service Provider Supervisors.
- (6) Contractor shall complete the Wraparound Fidelity Index Short Form (WFI-EZ) for each youth and caregiver enrolled in Wraparound after six months of being enrolled in Wraparound.
- (7) Contractor shall utilize WFI-EZ Report 8 to identify specific focus areas for improvement in WrapTrack. These items shall be the target of ongoing program improvement and scores shall be monitored over time for progress. The report 8 shall be shared with SOC Advisory Council no less than four times per year. A minimum of 35 percent response rate of youth enrolled is needed for statistical significance.
- (8) Contractor shall work with OHA-identified technical assistance entities to ensure the implementation and sustainability of SOC values, principles and governance structures, Fidelity Wraparound practice and youth and family partnerships. Contractor shall follow guidelines in the Oregon Best Practice Guide, as described at this location: <https://www.pdx.edu/ccf/best-practice-guide>.

- (9) Adherence to the Wraparound model is measured using the Wraparound Fidelity Index and other tools that are part of the Wraparound Fidelity Assessment System (WFAS). Information on Fidelity monitoring tools for Wraparound is available at the following website: <https://depts.washington.edu/wrapeval/content/quality-assurance-and-fidelity-monitoring>.
- (10) Contractor shall work with OHA-identified technical assistance entities to administer a tool to identify, implement and measure Fidelity of its Wraparound services and supports to ensure that Team Facilitation and Wraparound Care Coordination are consistent with SOC values and are culturally relevant as described at the following website: <https://gucchd.georgetown.edu/products/SOCIssueBrief.pdf>

**d. System of Care (SOC)**

Coordination with child and family serving entities is necessary to ensure quality of care, family and young adult satisfaction and positive outcomes.

- (1) Contractor shall develop and implement cost-effective comprehensive, person-centered, individualized, and integrated community-based Child and Youth Behavioral Health services for Members, using System of Care (SOC) principles.
- (2) Contractor shall establish and maintain a functional System of Care in its service area in accordance with the Best Practice Guide located at <https://www.pdx.edu/ccf/best-practice-guide> including a Practice Level Workgroup, Advisory Committee and Executive Council with a goal of youth and family voice representation to be 51 percent. As long as the functions are carried out in Rural and Frontier areas, up to two System of Care Councils may be combined. Contractor shall work with any other CCO within the same region (if applicable) to ensure a singular, collaborative System of Care structure for the region.
- (3) Contractor shall have a functional SOC governance structure by the beginning of CY 2020 that consists of a practice level work group, advisory council, and executive council.
  - (a) The Practice Level Workgroup shall review Wraparound practice barriers, remove barriers when possible, and submit barriers that remain unresolved to the SOC Advisory Committee and/or Executive Council for resolution and/or advancement to the State System of Care Steering Committee.
  - (b) The Practice Level Workgroup consists of representatives of the Contractor, its providers, child serving agencies and other agencies including, young adults and Youth Adult Peer Support, families and Family partners, and advocacy organizations and reflective of local culture.
  - (c) The Advisory Committee shall advise on policy development, implementation, reviews fidelity and outcomes, and provides oversight using a strategic plan. It shall respond to system barriers which the Practice Level Workgroup cannot resolve, making recommendations to the Executive level as needed.
  - (d) The Advisory Committee consists of representatives of the Contractor, its providers, child serving agencies and other agencies including, young adults or Young Adult Peer Support, families and Family Partners, and advocacy organizations and reflective of local culture.

- (e) The Executive Council shall develop and approve related policies, shared decision-making regarding funding and resource development, review of project outcomes, and identification of unmet needs in the community to support the expansion of the service array.
- (f) The Executive Council consists of representatives of the Contractor, its providers, child serving agencies and other agencies including, young adults or Young Adult Peer Support, families and Family Partners, and advocacy organizations and reflective of local culture.
- (4) Contractor shall develop the following items prior to December 31, 2020:
  - (a) Charters and new Member handbooks for the Practice Level Work group, the Advisory Council and the Executive Council;
  - (b) An initial and ongoing System of Care Brief due annually to OHA affirming Contractor’s commitment to upholding SOC principles that includes the following components:
    - i. A summary of local issues addressed through the SOC governance structure; and
    - ii. The data-informed priorities for the following contract year.
  - (c) A quarterly report that tracks the barriers to implementing a SOC including resolved and unresolved barriers.
  - (d) Contractor shall submit the documents described in this subsection to the State Steering Committee at [statewideSOC@state.or.us](mailto:statewideSOC@state.or.us).

**e. Child and Youth Screening**

- (1) The Child and Adolescent Needs and Strengths Comprehensive Screening (CANS Oregon) is a multi-purpose tool developed to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services and supports. Only staff who have been credentialed by the Praed Foundation for administering the CANS Oregon (as found at <https://tcomtraining.com>) shall administer CANS Oregon to Members.
- (2) Contractor shall ensure a CANS Oregon is administered to a Member who is a child or youth and the data is entered into OHA approved data system according to the following eligibility and timeline criteria:
  - (a) Within 60 days of notification that a Member is entering foster care or from date of referral from DHS caseworker;
  - (b) Annually for a Member who was rated a “Level of Care” of 1 or higher on the initial CANS and remains in foster care;
  - (c) Within 60 days of notification of the approval of a request for a CANS Oregon and upon DHS caseworker referral;
  - (d) For Members being served through the high fidelity Wraparound care planning process according to timelines specified in section (5) of this Contract; or
  - (e) Members receiving psychiatric day treatment.

**f. Provider Training for Wraparound Services**

- (1) Contractor shall ensure providers (including Day Treatment, PRTS, SAIP and SCIP providers) have an understanding of Wraparound values and principles and the provider's role within the child and family team. Contractor shall ensure providers collaborate and participate in the Wraparound process.
- (2) Contractor shall ensure that the Team Observation Measure tool (TOM) 2.0 is implemented by a trained rater as implemented by the Wraparound Coach or Wraparound Supervisor to Wraparound Care Coordinators a minimum of six times within their first year of employment and a minimum of two times thereafter. Outcomes from the tool shall be submitted to OHA twice a year. Submission dates shall align with due dates for the Child and Adolescent Needs Assessments.

**5. Reporting**

**a. Integration Roadmap**

- (1) Contractor shall report annually to OHA on the performance expectations in this section. Reports shall be submitted for review and approval to OHA. Contractor shall ensure that its subcontractors and Participating Providers supply all required information to support the monitoring process.
- (2) Contractor shall report on timeliness of access to Behavioral Health services and the methodology used to make this calculation.
- (3) Contractor shall report on the percentage of Members receiving Behavioral Health services and the methodology used to make this calculation
- (4) Contractor shall report how Contractor ensures comprehensive screenings of Behavioral Health and physical health, using evidence-based screening tools, are occurring in physical, oral and Behavioral Health care settings and the methodology used to make this calculation.
- (5) Contractor shall report on the percent of prior authorizations that are required out of the total number of behavioral health covered services and the percent of prior authorized services that are approved within three (3) days.
- (6) Contractor shall report performance measures and implement evidence-based outcome measures, as developed by the OHA Metrics and Scoring Committee.
- (7) Contractor shall ensure all Behavioral Health providers enroll their Members in the Measures and Outcomes Tracking System (MOTS), or a similar program as specified by OHA. The details for MOTS reporting are located at the following website: <http://www.oregon.gov/oha/amh/mots/Pages/index.aspx>.
- (8) Contractor shall participate with OHA in a review of OHA provided data about the impact of these criteria on service quality, cost, outcome, and access.
- (9) Contractor shall report on cost and utilization of Behavioral Health services quarterly and annually in the Exhibit L.
- (10) Contractor shall report on wait time to appointment for access to Behavioral Health services.

- (11)** Contractor shall collect data to accurately quantify the percentage of Members at OSH, that once determined Ready To Transition (RTT) by OSH, are:

  - (a)** Discharged within 20 days;
  - (b)** Discharged into ACT services;
  - (c)** Discharged to Secure Residential Treatment Facilities; and
  - (d)** Admitted to ED, ACPF, OSH, or jail (or who die) within 30 days and 180 days of discharge.
  
- (12)** Contractor shall report on the percentage of Members receiving each of the following Behavioral Health services, categorized by MH and SUD, each quarter:

  - (a)** ACT
  - (b)** Supported Employment
  - (c)** Peer Delivered Services
  - (d)** Non-Secure Residential
  - (e)** Residential
  - (f)** Acute Care
  - (g)** Emergency Department
  - (h)** State Hospital
  - (i)** Other
  
- (13)** Contractor shall report on the number of Members who are:

  - (a)** Referred to ACT and the disposition of referral, in each of the following categories:

    - i.** Admitted to and receiving ACT;
    - ii.** Denials by ACT program;
    - iii.** Referral was reviewed for appropriateness;
    - iv.** The length of time for resolution;
    - v.** Referral resulted in an individual being enrolled in ACT;
    - vi.** Referral resulted in a denial of ACT services;
    - vii.** Referral resulted in the member being sent a Notice of Adverse Benefit Determination.
  
- (14)** Contractor shall report on the percentage of Members with SPMI admitted to ACPFs for MH diagnosis in each of the following categories:

  - (a)** Discharged with documentation of linkages to appropriate behavioral and primary health care prior to discharge;
  - (b)** Discharged with documentation of warm handoffs;
  - (c)** Members that received a follow-up visit within 7 days;
  - (d)** Homeless members who are connected to a housing provider with an appropriate documented housing assessment;

- (e) Members who are readmitted within 30 and 180 days; and
  - (f) Members in the categories above who are readmitted two or more times within six months.
- (15) Contractor shall report on the number of Members with SPMI who are admitted to EDs for MH diagnosis including the following data points:
- (a) The percent of Members who are admitted,
  - (b) The range and average length of stay;
  - (c) Whether the Member left the ED with appropriate connection to services and who have follow-up visit within 7 days; and
  - (d) Whether the Member was readmitted to ED two or more times within six months.

**b. Reporting – Children and Youth Members**

- (1) Contractor shall report on children receiving Wraparound services and supports quarterly.
- (2) Contractor shall report on CANS data quarterly, using the OHA-approved assessment and outcomes tool to the OHA approved reporting and analytics service system in order to track outcomes and review progress. Entries shall occur within 30 days of start of service, every 90 days after the initial entry and upon exit from service.
- (3) Contractor shall report on children receiving high fidelity Wraparound Services using the OHA approved assessment and outcomes tool. Contractor shall submit the results of this assessment to the OHA-approved reporting and analytics service system in order to track outcomes and review progress. Entries shall occur within 30 days of start of service, every 90 days after the initial entry and upon exit from service. These practices shall be in alignment with OAR 309-Wraparound Rule.

**6. Providers**

- a. Contractor shall ensure Contractor’s staff and providers are trained in recovery principles, motivational interviewing, integration, and Foundations of Trauma Informed Care (<https://traumainformedoregon.org/tic-intro-training-modules/>) and provide regular, periodic oversight and technical assistance on these topics, to providers.
- b. Contractor shall require providers, in developing individual service and support plans for Members, to assess for Adverse Childhood Experiences (ACEs), trauma and resiliency in a culturally responsive manner, using a trauma informed framework as indicated.
- c. Contractor shall ensure that providers under The Drug Addiction Treatment Act of 2000, Title 42 Section 3502 Waiver are permitted to treat and prescribe Buprenorphine for opioid addiction in any appropriate practice setting in which they are otherwise credentialed to practice and in which such treatment would be Medically Appropriate.
- d. Contractor shall ensure that employees or providers who evaluate Members for access to, and length of stay in, Substance Use Disorders programs and services use the American Society of Addiction Medicine (ASAM) Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition-Revised (PPC-2R) for level of care placement decisions, and that they have the training and background necessary to evaluate medical necessity for Substance Use Disorder Services using the ASAM.
- e. Contractor shall report the number of staff trained in the previous 12 months on recovery principles, motivational interviewing, integration, and Foundations of Trauma Informed Care.
- f. Contractor shall require mental health and substance use disorder programs be licensed or certified by OHA to enter the provider network if licensure is required by OHA.

## **Exhibit N-Social Determinants of Health and Health Equity**

### **1. Community Advisory Council (CAC)**

- a.** To ensure the health care needs of the members of the community are being addressed, Contractor shall establish a CAC which:
- (1)** Includes representatives of the community and of each county government served by the Contractor, but consumer representatives must constitute a majority of the membership;  
A consumer representative is defined as a person serving on a community advisory council who is a current OHP member or a parent/guardian/primary caregiver of a current OHP member; consumer representatives can be age 16 or older. If a consumer representative's membership in OHP ends, they can be counted as a consumer representative for six months after the end of membership but not after that time (though they may remain a CAC member).
  - (2)** Ensures diverse membership, with a specific emphasis on those representing populations who experience health disparities;
  - (3)** Has its membership selected by a committee comprised of an equal number of representatives from each county served by the Contractor and members of Contractor's governing body;
  - (4)** Meets no less frequently than once every three months. Meetings shall follow requirements as outlined in ORS 414.627;
  - (5)** Posts a report of its meetings and discussions to the Contractor's CCO website and other websites as appropriate to keep the community informed of the CAC's activities. The CAC, the Contractor's governing body or a designee of the CAC or Contractor's governing body has discretion as to whether public comments received at meetings that are open to the public will be included in the reports posted to the website and, if so, which comments are appropriate for posting;
  - (6)** If the regular CAC meetings are not open to the public and do not provide an opportunity for members of the public to provide written and oral comments, Contractor shall hold semiannual meetings that:
    - (a)** Are open to the public and attended by the members of the CAC;
    - (b)** Report on the activities of the Contractor and the CAC;
    - (c)** Provide written reports on the activities of the Contractor;
    - (d)** Provide the opportunity for the public to provide written or oral comments; and
    - (e)** Posts to the Contractor's CCO website contact information for, at a minimum,
      - i.** The CAC chairperson; and
      - ii.** A member of the CAC or a designated staff member of the Contractor
  - (7)** Contractor is not required by OHA to subject meetings of the CAC to ORS 192.610 to 192.710, the Public Meetings Law.

- b.** Duties of the CAC include, but are not limited to:
  - (1) Identifying and advocating for preventive care practices to be utilized by the Contractor
  - (2) Overseeing a Community Health Assessment (CHA) and adopting a Community Health Improvement Plan (CHP) to serve as a strategic plan for addressing health disparities and meeting health needs for the communities in the Service Area(s); and
  - (3) Publishing an annual report on the progress of the CHP.
- c.** Contractor shall complete and submit to OHA a CAC member composition and alignment report that contains:
  - (1) Description of the demographic composition of CAC membership;
  - (2) Description of data sources used to inform CAC alignment with Contractor’s member demographics;
  - (3) Description of barriers and efforts to increase alignment;
  - (4) Description of how Contractor defines its member demographics and diversity;
  - (5) Description of the intent and justification for CAC composition;
  - (6) How Contractor’s CAC representation is in alignment with CHP priorities and the percentage of OHP members on Contractor’s CAC;
  - (7) A description of the CAC’s ongoing role in decision-making about HRS Community Benefit Initiatives, social determinants of health spending decisions, and other community-based initiatives; and
  - (8) Contractor’s organizational chart. The organizational chart shall indicate:
    - (a) How information flows between the CCO and CAC;
    - (b) The connection between the CAC, CCO Board of Directors and any other CCO committees;
    - (c) The CAC representation on the CCO board of directors;
    - (d) A narrative description of relationship between the CAC and CCO board of directors; and
    - (e) All components described above, in relation to tribes and/or tribal advisory committee as applicable.
  - (9) CAC reports shall be posted publicly on OHA’s website, with demographics of CAC membership redacted.
  - (10) The CAC report is due on June 30<sup>th</sup> of each year beginning June 30, 2021.

**2. Community Health Assessment (CHA) and Community Health Improvement Plan (CHP)**

- a.** The Contractor, through its CAC, shall adopt a CHA and a CHP with responsibilities identified in OAR 410-141-3145 and in compliance with ORS 414.627 and ORS 414.626. This includes, but is not limited to developing a CHA and CHP that:
  - (1) Is transparent and public in process and outcomes. Contractor shall assure that the contents and development of the CHP comply with ORS 414.627 and ORS 414.629;
  - (2) Is a shared CHA and has shared CHP priorities and strategies with LPHAs, nonprofit hospitals, any other CCOs that share a portion of the Contractor’s service area, and any

- federally recognized tribe in the service area that is developing or already has a CHA and/or CHP;
- (3) Includes in the CHP at least two State Health Improvement Plan (SHIP) priorities, based on local need and the statewide strategies being implemented;
  - (4) Includes SDOH-HE partners and organizations, counties, THWs, and tribes in development of the CHA and CHP; and
  - (5) Involves school nurses, school mental health providers, and individuals representing child and adolescent health services in the development of the CHP.
- b.** To the extent practicable, Contractor shall include in the CHA and CHP a strategy and plan for:
- (1) Working with the Early Learning Council, Early Learning Hubs, the Youth Development Council, Local Mental Health Authority, oral health care providers, the local public health authority, community-based organizations, hospital systems and the school health providers in the Service Area/region; and
  - (2) Coordinating the effective and efficient delivery of health care to children and adolescents in the community.
- c.** A CHP must:
- (1) Be based on research, including research into adverse childhood experiences;
  - (2) Identify funding sources and additional funding necessary to address the health needs of children and adolescents in the community and to meet the goals of the plan;
  - (3) Evaluate the adequacy of the existing school-based health center (SBHC) network to meet the specific pediatric and adolescent health care needs in the community and make recommendations to improve the SBHC and school nurse system, including the addition or improvement of electronic medical records and billing systems;
  - (4) Take into consideration whether integration of school-based health centers with the larger health system or system of community clinics would further advance the goals of the plan;
  - (5) Improve the integration of all services provided to meet the needs of children, adolescents, and families; and
  - (6) Focus on primary care, behavioral and oral health, and address promotion of health and prevention, and early intervention in the treatment of children and adolescents;
  - (7) Include, in the activities, services and responsibilities defined in the CHP, a plan and strategy for integrating physical, behavioral and oral health; and
  - (8) Include the findings of the CHA and the method for prioritizing health disparities for remedy.
- d.** Contractor, with its CAC, shall develop baseline data on health disparities. Contractor may seek guidance from the OHA Office of Equity and Inclusion in that development. Contractor shall include in the CHA the identification and prioritization of health disparities among Contractor's diverse communities, including those defined by race, ethnicity, language, disability, age, gender, sexual orientation, and other factors in its Service Areas. Contractor shall include representatives of populations experiencing health disparities in CHA and CHP prioritization.

- e. Contractor shall provide opportunities for IHCPs to contribute in the Contractor’s development of the CHA and CHP, which may include the following actions: including tribes and IHCPs to contribute and gather health disparities data, identification of CHP priorities, and allowing IHCP feedback and review of the CHA and CHP.
- f. The CHA and CHP adopted by the CAC shall describe the full scope of findings, priorities, actions, responsibilities, and results achieved. The CHP may include, as applicable:
  - (1) Findings from the shared community health assessment and any other applicable community health assessments completed within the Contractor’s service area;
  - (2) Findings on health needs and health disparities from community partners or previous assessments;
  - (3) Findings on health indicators, including the leading causes of chronic disease, injury and death in the Service Area;
  - (4) Evaluations of and recommendations for adequacy of existing school-based health systems in meeting the needs of specific pediatric and adolescent health care needs in the community;
  - (5) Analysis and development of public and private resources, capacities and metrics based on ongoing CHA activities and population health priorities;
  - (6) Public Health Accreditation Board standards for CHPs;
  - (7) Health policy;
  - (8) System design issues and solutions;
  - (9) Outcome and Quality Improvement plans and results;
  - (10) Integration of service delivery approaches and outcomes; and
  - (11) Workforce development approaches and outcomes.
- g. Contractor shall provide a copy of the CHA and the CHP, and annual progress reports using the guidance and template provided by OHA at <https://www.oregon.gov/oha/HPA/dsi-tc/Pages/CCO-CHIP.aspx>, to the Contract Administration unit, on or before June 30<sup>th</sup> of each year. The CHA, CHP and annual progress report must be submitted as follows:
  - (1) The CHA and CHP must be updated at least every five years, but may be updated more frequently than every five years;
  - (2) The updated CHA and CHP must be submitted along with the annual progress report;
  - (3) If Contractor has an existing CHA or CHP that is not representative of the Contractor’s current service area, Contractor must submit a new CHA and CHP in June 2021; and
  - (4) The progress reports shall identify goals, benchmarks, and targets for priority areas, including data used to evaluate goals, benchmarks, and targets.

**3. Social Determinants of Health and Health Equity**

- a. Contractor shall spend a portion of annual net income or reserves on services designed to address health disparities and the social determinants of health, according to requirements in Oregon Administrative Rule and ORS 414.625(1)(b)(C).
- b. Contractor shall submit to OHA, by March 15, 2020, an implementation plan using the template provided by OHA that includes the selected priorities for health disparities and SDOH-HE

required spending in the subsequent year. The selected priorities shall be aligned with the CHP and identified from analysis of any existing CHP priorities that meet the OAR SDOH-HE definition and fall into one of four SDOH-HE domains: Economic Stability, Neighborhood and Built Environment, Education, and Social & Community Health. Contractor must include the OHA-designated statewide priority for SDOH-HE spending, namely: housing-related services and supports, including supported housing, as defined in this contract. Contractor shall comply with future statewide priorities as set by OHA. Contractor may select additional priorities aligned with CHP priorities according to community need. The plan shall identify any infrastructure needs or gaps for addressing the selected priorities and ways to satisfy those needs or gaps.

- c.** Contractor shall submit to OHA, by April 30, 2021, a proposal for how Contractor intends to direct its SDOH-HE spending for SDOH-HE, for approval by OHA. OHA reserves the right to review and require changes to the proposal and to provide guidance on appropriate use of funds. The proposal shall include a description of the following:
- (1) A list of selected priorities, aligned with the Contractor’s CHP, for SDOH-HE spending, including justification of any changes from the Contractor’s implementation plan;
  - (2) Identification of how projects or initiatives address a priority area of SDOH-HE;
  - (3) How SDOH-HE partner(s) were selected;
  - (4) Any ownership, business, or financial relationship between SDOH-HE partner(s) and Contractor, including a completed ownership disclosure form;
  - (5) An evaluation plan for each project or initiative, including expected outcomes, the number of OHP members and community members served, and how impact will be measured;
  - (6) A budget proposal indicating the amount of funding that will be directed to each SDOH-HE partner;
  - (7) Copies of all written agreements to SDOH-HE partners for directed SDOH-HE spending;
  - (8) A description of the CAC’s role in selecting the proposed project; and
  - (9) A data sharing agreement that details applicable HIPAA and other state and federal privacy and security requirements for protected personal information sharing.
- d.** Contractor shall enter into a formal written agreement with each SDOH-HE partner(s) to direct a portion of required SDOH-HE spending to SDOH-HE partner(s). The agreement shall contain the following information and disclosures:
- (1) Contract term;
  - (2) Legal names for all entities;
  - (3) Any relationship or financial interest that may exist between the SDOH-HE partner and Contractor, including membership on the governance board or CAC;
  - (4) The category of SDOH-HE partner. If the partner does not qualify as one of the listed categories, CCOs must receive prior written approval from OHA;
  - (5) How contractor will distribute funds to partners,
  - (6) The scope of work to be performed, including the domain of SDOH-HE addressed and the targeted population;

- (7) Whether Contractor will refer members to the SDOH-HE partner;
  - (8) The geographic area to be covered;
  - (9) How Contractor will measure and evaluate outcomes; and
  - (10) How Contractor will collect and report data related to outcomes.
- e. Contractor shall submit to OHA a copy of any agreement with SDOH-HE partners no later than 30 days after the agreement is executed. Contractor shall submit to OHA copies of all agreements with SDOH-HE partners for required 2021 spending with Contractor’s full proposal by April 30, 2021.
- f. Contractor shall provide narrative and financial reporting of expenditures to OHA in the manner prescribed by the agency.
- g. OHA intends to establish a two-year incentive arrangement – the SDOH-HE Capacity-Building Bonus Fund (“SDOH-HE Bonus Fund”) – to offer monetary bonus payments above and beyond the capitation rate to Contractors that meet SDOH-HE-related performance milestones and metrics. Performance will be evaluated and payments awarded to qualifying Contractors beginning CY 2021. The SDOH-HE Bonus Fund will be contingent on availability of funds under the Medicaid growth cap and any required CMS approval.
  - (1) By November 2020, OHA will issue to Contractors:
    - (a) The list of performance milestones, benchmarks, and specifications for CY2021
    - (b) Full program documentation, including SDOH-HE Bonus Fund structure, methodology and disbursement timeline for the subsequent year, published on the OHA website.
    - (c) The estimated maximum payment each CCO could qualify to receive in CY 2021 if it meets all performance milestones under the program
    - (d) The estimated percentage of CY 2021 capitation rates CCOs could qualify to receive in CY 2022 under the SDOH-HE Bonus Fund (i.e. estimated percentage of CY 2022 payments)
  - (2) Contractor shall align SDOH-HE Bonus Fund expenditures with SDOH-HE priorities for required spending, including the statewide priority of housing-related services and supports.
  - (3) Contractor shall provide OHA with narrative and financial reporting of SDOH-HE Bonus Fund expenditures, including any funds distributed to SDOH-HE partners, in the manner and form required by OHA.

#### **4. Health-Related Services**

- a. In addition to Covered State Plan Services, Contractor shall include Health-related services, in accordance with OAR 410-141-3150, 45 CFR §158.150 or 45 CFR §158.151 that are consistent with the goal of achieving Member wellness and the objectives of an individualized care plan, or the goal of improving population health and health care quality. Health-related services must be coordinated by the Contractor and may be in collaboration with the PCPCH or other PCP in the DSN. Health-related services must be administered in accordance with Contractor’s policy.
- b. Services covered under this Contract may be substituted with or expanded to include Health-related services, in compliance with Contractor’s policy, as agreed to by the Member and, as appropriate, the family of the Member, as being an acceptable alternative.

- c. Contractor shall establish written policies and procedures in alignment with the requirements in Oregon Administrative Rule for administering Health-related services. The policies and procedures shall enable a Participating Provider to order and supervise the delivery of Health-related services. Contractor shall submit these policies, as follows:
  - (1) To the OHA Contract Administration Unit annually no later than October 1st.
  - (2) To OHA Contract Administration Unit upon any significant changes, prior to formal adoption of the policy. OHA will notify Contractor within 30 days of the compliance status of the policy.
  - (3) To the OHA Contract Administration Unit anytime upon OHA request. OHA will notify Contractor within 30 days of the compliance status of the policy.
- d. Contractor shall develop, for implementation starting in 2021:
  - (1) Internal measures of clinical value and efficiency that will inform delivery of services to members;
  - (2) A strategy to use health-related services to reduce avoidable health care services utilization and cost;
  - (3) A strategy for spending on health-related services to create efficiency and improved quality in service delivery; and
  - (4) A process analysis Contractor will use to evaluate investments in health-related services and initiatives to improve members Social Determinants of Health.

## 5. Health Plan

### a. Development of Plan

- (1) Contractor shall develop and begin to implement a Health Equity Plan by the beginning of CY2020.
- (2) Contractor shall annually update and submit its Health Equity Plan by March 15 of each contract year. Beginning in contract year 2021, Contractor shall submit an annual progress assessment. OHA will review Health Equity Plans submissions. Accountability measures will be developed and updated in consultation with the Oregon Health Policy Board's Health Equity Committee.
- (3) Contractor shall include in its annual progress assessment the following information related to its Health Equity Plan implementation:
  - (a) Increased capacity and leadership for health equity and cultural responsiveness
  - (b) How Contractor has used race, ethnicity, language and disability (REAL+D) and culturally and linguistically appropriate services (CLAS) in the organization and the provider network.

Guidance documents for the Health Equity Plan development will be provided by OHA.

- (4) The Health Equity Plan shall include a training program across Contractor's organization and its provider and subcontractor network and shall designate a single point of accountability within Contractor's organization to be accountable for its implementation.
- (5) The Health Equity Plan report includes three required sections:
  - (a) Narrative of the Health Equity Plan development process.

- (b) Strategies, goals, objectives, activities, and metrics.
- (c) Organizational and Provider Network Cultural Responsiveness and Implicit Bias Training and Education Plan.

**b. Narrative Health Equity Plan Development and Implementation - Requirements**

The Narrative Section shall address each of the following components:

- (1) Description of the Contractor’s organization and organizational commitment to Health Equity;
- (2) Narrative description of the general population served by Contractor, Contractor’s workforce demographics, and CAC demographic composition, identifying the data source used to define the CAC demographic composition. If member demographic data is available, Contractor shall include it;
- (3) Description of Contractor’s organizational oversight and accountability structure to support the implementation of the Health Equity Plan components. Description shall include the role of the single point of accountability for Health Equity Plan development and implementation;
- (4) Narrative description of how the Health Equity Plan was developed including stakeholder participation, CAC involvement, and how the Health Equity Plan will be updated. Contractor is expected to provide evidence that the process for the development of the Health Equity Plan included clearly defined and realistic objectives that were community and stakeholder informed. Evidence may include a description of how community and stakeholder engagement impacted the plan development process; how the Contractor informed potential participants of the proposed development, implementation and outcomes, and how the Contractor plans to provide regular updates to those community members and stakeholders involved in the development process;
- (5) Contractor’s plan for community engagement and communication throughout the planning, implementation, and evaluation of the plan and its deliverables;
- (6) An assessment of the Contractor’s organizational capacity to advance health equity, including stakeholder engagement, current capabilities and assets, and future goals for developing additional capacity; and
- (7) Narrative description of the general expectations for the Health Equity Plan, expected organizational and community health impact of the strategies and initiatives included in the plan, and their influence in the social determinants of health and organization and community-wide efforts to reduce health inequities.

**c. Strategies, Goals, Objectives, Activities, and Metrics - Requirements**

The Strategies, Goals, Objectives, Activities and Metrics section shall include:

- (1) Conflict and grievance resolution processes that are culturally responsive and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
- (2) Collection, analysis, and maintenance of accurate and reliable demographic data (i.e. REAL+D).
- (3) Standards for and measurement of success of implementation of the Health Equity Plan over the five-year period. Contractor shall develop at least one strategy under each of the

eight Health Equity Focus areas (CY 2020 years are listed below). OHA reserves the right to modify Health Equity Focus areas in future years.

- (4) Provision of effective, equitable, understandable, and respectful quality care and services
- (5) Organizational governance and leadership to promote health equity (i.e. incorporation of CLAS)
- (6) Recruitment of culturally and linguistically competent leadership and workforce
- (7) Training and education for culturally and linguistically responsive governance, leadership and workforce (i.e. Training activities such as Non-discrimination and civil rights, compliance with ACA 1557, utilization of Traditional Health Workers, community engagement, accessibility, among others)
- (8) Language assistance accessibility, appropriateness, and quality of language services (i.e. use of qualified and certified healthcare interpreters; quality assessment of language service provision)
- (9) Development and provision of materials (print, multimedia, etc.), plain language, alternate formats and the use of IT tools for patient/member engagement and education (i.e. literacy and plain language review, the offering of alternate formats, IT tools for patient engagement, including in languages other than English).
- (10) Conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent and resolve conflicts or complaints
- (11) Collection, analysis, and maintenance of accurate and reliable demographic data (REAL+D)

**d. Organizational and Provider Network Cultural Responsiveness and Implicit Bias Training and Education Plan- Requirements**

- (1) Contractor shall incorporate training activities into their existing organization-wide training plans that address Cultural Responsiveness and Implicit Bias in the workforce. Contractor shall require and provide training or ensure training is provided on implicit bias for all of Contractor's staff and provider network.
- (2) Contractor shall use the criteria developed by the Cultural Competence Continuing Education Committee for the selection of training and education resources on cultural competency and responsiveness for Contractor's staff and provider network.
- (3) Contractor, when incorporating cultural responsiveness training activities into its training plans, shall adopt the definition of cultural competence in OAR 943-090-0010 for Cultural Competence Continuing Education for Health Care Professionals.
- (4) Contractor shall ensure that workforce and provider network training offerings include at a minimum the following fundamental areas or a combination of all:
  - (a) Implicit Bias/Addressing structural barriers and systemic oppression
  - (b) Language Access; Use of Health Care Interpreters
  - (c) CLAS Standards
  - (d) Adverse Childhood Experiences/Trauma Informed Care
  - (e) Uses of data to advance health equity
  - (f) Universal Access or accessibility in addition to ADA

- e. Contractor shall provide evidence that it has adopted the aforementioned criteria and core competencies.
- f. Contractor shall provide details of their training activities, including reporting of training subjects, content outlines, objectives, target audiences, delivery system, evaluations, training hours, training attendance, and trainer qualifications. Contractor shall supply this information when submitting its Health Equity Plan .
- g. Contractor shall set training goals and objectives that are measurable and that will enable Contractor and OHA to monitor and measure progress on the completion of trainings and the impact of training on the development of desired competencies.
- h. For CY2020 only:
  - (1) The Health Equity Plan shall include the identification of a single point of accountability. The single point of accountability shall facilitate the transmission of information between OHA, the Health Equity Committee, and Contractor on health equity activities and the delivery of culturally responsive and linguistically appropriate services. The single point of accountability shall participate on Health Equity Committees and other committees and workgroups when required.
  - (2) Contractor shall provide the following to OHA:
    - (a) A description of the roles and responsibilities of the single point of accountability;
    - (b) How the single point of accountability reports to CCO leadership; and

Evidence of the single point of accountability’s budgetary decision-making and resource allocation authority.

## 6. Traditional Healthcare Workers

- a. Contractor shall implement the **THW Integration and Utilization Plan** developed as part of the application for RFA 4690. The THW Integration and Utilization Plan must describe how Contractor will:
  - (1) Integrate THWs into the delivery of services;
  - (2) Communicate to members about the benefits and availability of THW services;
  - (3) Increase THW utilization;
  - (4) Implement THW Commission best practices;
  - (5) Measure baseline utilization and performance over time;
  - (6) Utilize the THW Liaison position to improve access to members and increase recruitment and retention of THWs in its operations.
- b. Contractor shall work in collaboration with THW Commission to implement the Commission’s best practices, and coordinate with the OHA Office of Equity and Inclusion for technical assistance on implementation as needed.
- c. As part of the implementation of Contractor’s THW Integration and Utilization Plan, Contractor shall clearly and consistently communicate to members about the benefits and availability of THW services.
- d. Contractor shall collect data to measure the integration and utilization of THWs using the reporting template provided by OHA. Contractor shall collect and submit the information

collected for Contractor's service area by April 1 of each contract year for data collected in the prior contract year.

Data to be collected and submitted includes:

- (1) An assessment of member satisfaction with THW services;
  - (2) Ratio of THWs to the total number of members;
  - (3) Number of THWs employed by Worker Type (FTE/Contracted);
  - (4) Number of requests from members for THW services (by THW types);
  - (5) Number of engagements of THWs as part of the Member's Care Team (by THW types);
  - (6) Demographics of THWs and CCO membership: including Race, Ethnicity, Language, Disability.
  - (7) The number of clinic and community-based THWs
- e. Contractor shall ensure that encounter claims are submitted for any THW interactions that are eligible to be submitted and processed as encounter claims.
- Contractor shall collect data for each of the following THW types:
- (1) Community Health Workers
  - (2) Doulas
  - (3) Peer Support Specialists including Adult Addictions, Adult Mental Health, Family and Youth Support Specialists
  - (4) Peer Wellness Specialists including Adult Addictions, Adult Mental Health, Family and Youth Support Specialists
  - (5) Patient Health Navigators
- f. Contractor shall document the number of interactions between THWs and members in each setting:
- (1) Clinic Setting
  - (2) Non-Clinic Setting
  - (3) Community-Based Setting
- g. Contractor shall document and report to OHA on each type of payment model used by Contractor to reimburse THWs and the number of THWs paid under each payment model it utilizes.
- h. Contractor shall designate an employee as a THW Liaison. The THW Liaison shall act as a hub for Members and THWs in the Contractor's service delivery system. Contractor shall utilize the THW Liaison position to improve access to Members and increase its recruitment and retention of THWs in its operations, and to implement the provisions of its THW Integration and Utilization Plan.

**Exhibit C-Attachment 1**  
**CCO Specific Rates**