OREGON HEALTH PLAN BRIDGE - BASIC HEALTH PROGRAM

Amended and Restated

HEALTH PLAN SERVICES CONTRACT

Coordinated Care Organization

Contract # «BHP_Contract_»

with

«Registered_Name» «Registered_ABN»

Contents

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OREGON HEALTH PLAN BRIDGE - BASIC HEALTH PLAN
SERVICES CONTRACT
COORDINATED CARE ORGANIZATION

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

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

«Physical_AddressStreet»
«Physical_AddressCityStateZip»

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

GENERAL PROVISIONS

1. Purpose; Effective Date; Duration of Contract

1.1. **Contract Effective Date**. This Oregon Health Plan Bridge – Basic Health Program Services Contract ("**OHP Bridge - BHP Contract**" or "**Contract**") effective as of July 1, 2024 ("**Effective Date**"),is hereby amended and restated in its entirety effective as of January 1, 2025 ("**2025 A&R Effective Date**"), regardless of the date of signatures and remains in effect, unless terminated earlier or extended as provided for herein, up through and including, December 31, 2026. The amendment and restatement of this Contract does not affect its terms and conditions for Work prior to the 2025 A&R Effective Date. Notwithstanding the foregoing, this Contract may be amended upon expiration of each Contract Year.

1.1.1. The Term of this Contract commences on its Effective Date and, unless earlier terminated in accordance with the terms and conditions of this herein, expires on December 31, 2026. Notwithstanding the foregoing, this Contract may be amended and restated for a subsequent calendar year commencing on January 1. In the event Contractor is not in breach of this Contract at the end of the Contract Year ending on December 31, 2025, OHA will offer, subject to any amendments hereto, to Renew this Contract for one successive Contract Year (January 1, 2026 through to the end of the day on December 31, 2026) following the Contract Year ending on December 31, 2025.

1.1.2. Neither expiration nor termination of this Contract extinguishes or prejudices OHA's right to enforce this Contract with respect to any default by Contractor.

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

1.2. Subject to the terms and conditions of this Contract, Contractor shall provide health care services to individuals enrolled in the programs specified in Section 1.2.1 below of these General Provisions. All payments to Contractor under this Contract will be paid from a collection of state and federal moneys maintained by the Oregon Health Authority for the purpose of implementing and carrying out the Oregon Health Plan Bridge – Basic Health Program ("**OHP Bridge - BHP**"), as described under OAR 410-115-0010 ("**OHP Bridge - BHP Trust Fund**"), unless otherwise specified in this Contract. Any such payments to Contractor that are not paid from the OHP Bridge - BHP Trust Fund will be paid from State of Oregon general funds ("**State Funds**") only. In no event will there be any federal financial participation involving Medicaid or CHIP funds (hereinafter referred to individually and collectively as "**Medicaid Funds**"). However, there will be federal financial participation involving funds received through United States Department of Health and Human Services ("**HHS**"), which has delegated regulatory oversight and administration of OHP Bridge - BHP to, notwithstanding its name, the Centers for Medicare and Medicaid.

To distinguish this Contract from the separate Medicaid Contract and Non-Medicaid Contract (also known as the Healthier Oregon or HOP Contract), this Contract may at times be referred to as either the "**OHP Bridge - BHP Contract**" or "**BHP Contract.**"

Under a separate Medicaid contract, Contractor provides Medicaid services to Medicaid beneficiaries in accordance with Applicable Law, under a second, separate Non-Medicaid contract, Contractor provides Medicaid-equivalent services to individuals who would be eligible for Medicaid services but for their immigration status in accordance with Applicable Law. Individuals provided services through this OHP Bridge - BHP Contract shall not be provided services under the Medicaid or Non-Medicaid Contracts. However, by submitting an application in response to RFA OHA-4690-19 and accepting OHA's award of the Medicaid Contract, Contractor understood that it agreed to enter into companion Non-Medicaid contracts, such as this Contract and the Non-Medicaid Contract, both of which require Contractor to provide Medicaid-equivalent services or near Medicaid-equivalent services to individuals not eligible for Medicaid. The services required to be provided to the individuals identified in this Contract are substantially similar to those provided to Medicaid beneficiaries under the Medicaid Contract and Non-Medicaid beneficiaries under the Non-Medicaid Contract. Likewise, as further detailed in Section 4.1.2 below of these General Provisions, the terms and conditions of this Contract, the Medicaid and Non-Medicaid Contracts are also substantially similar. In no event shall Contractor, its Providers, Subcontractors, and other third-parties with which Contractor contracts treat OHP Bridge - BHP Members (as defined in Section 1.1.2 below of this Section 1) differently or otherwise distinguish such Members from Contractor's Medicaid and Non-Medicaid Members.

1.2.1. OHP Bridge – BHP is the result of Enrolled Oregon House Bill 4035 (2022 Regular session). Under House Bill 4035, the Oregon Legislature created a task force for the purpose of developing a proposal for a "bridge" from Medicaid disenrollment resulting after the end of the Covid-19 Public Health Emergency to new, affordable health insurance coverage for those individuals who, due to income fluctuations, regularly enroll and disenroll from other medical assistance or health care coverage. The services Contractor is required to provide to the

individuals identified in OAR 410-115-0005 is the result of the proposal developed by the task force and complies with Section 1331 of the Affordable Care Act of 2010 (the "**ACA**") and 42 CFR Part 600, which established the Basic Health Program ("**BHP**"). Section 1331 of the ACA and 42 CFR Part 600 permit states to enter into contracts for standard health plans providing at least essential health benefits to individuals in lieu of offering the same individuals the opportunity to enroll in coverage through the Affordable Insurance Exchange. OHA has, as a reminder of the genesis of the health plan's creation, while also being mindful of the language used in the federal legislation, named Oregon's Basic Health Program OHP Bridge - BHP.

1.2.2. In accordance with OAR 410-200-0438 the individuals enrolled in OHP Bridge - BHP and entitled to the services agreed to under this Contract are, those who: (i) are no younger than 19 years of age and under age 65, (ii) have a monthly household income greater than 138% of the federal poverty level (FPL) through 200% of the FPL for the applicable family size, (iii) have an annual household income for the applicable Plan Year that is greater than 100% of the FPL through 200% of FPL for the applicable family size, and (iv) meet the citizenship requirements identified in OAR 410-200-0215. The foregoing individuals are referred to in this Contract as "**OHP Bridge - BHP Member(s)**" or "**Members**."

2. Contract Administrators

2.1. Contractor designates:

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

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

2.2. OHA designates:

Melissa A. Classen
OHA HSD
500 Summer Street NE, E35
Salem, Oregon 97301
Phone: 503-979-8390
Email: Melissa.A.Classen@oha.oregon.gov

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

3. Enrollment Limits and Service Area

3.1. Contractor's maximum Enrollment limit by County as identified in Section 3.1 of the General Provisions to Contractor's Medicaid Contract includes the OHP Bridge – BHP Members to whom Contractor will provide services in accordance with this Contract.

3.2. Contractor's # total maximum Enrollment limit as identified in Section 3.2 of the General Provisions to Contractor's Medicaid Contract includes the OHP Bridge-BHP Members to whom Contractor will provide services in accordance with this Contract. this Section 3.2 of the General Provisions to Contractor's Medicaid Contract is incorporated by reference as though fully set forth in this Section. Enrollment under this Contract may be increased from time to time in accordance with Exhibit B, Part 3 Section 8 of this Contract; however, such additional Enrollment does not create a new maximum Enrollment limit.

3.3. Contractor shall comply with any and all new Oregon administrative rules ("OARs") that may be adopted during Contract Year two (2025) that are related to Member Enrollment.

4. Entire Contract; Administration of Contract; Interpretation of Contract

4.1. Entire Contract

This Contract consists of the preamble and Secs. 1 through 5 (the "General Provisions"), together with the following Exhibits and Exhibit attachments, and Reference Documents described in Sec. 4.1.1 below of these General Provisions to the Contract:

Exhibit A: Definitions
Exhibit B: Statement of Work
Exhibit C: Consideration*
Exhibit D: Standard Terms and Conditions**
Exhibit E: Federal Terms and Conditions
Exhibit F: Insurance Requirements
Exhibit G: Reporting of Delivery System Network Providers, Cooperative Agreements, and Hospital Adequacy
Exhibit H: Value-Based Payment
Exhibit I: Grievance and Appeal System
Exhibit J: Health Information Technology
Exhibit K: Social Determinants of Health and Health Equity
Exhibit L: Solvency Plan, Financial Reporting, and Sustainable Rate of Growth
Exhibit M: Behavioral Health
Exhibit N: Privacy and Security

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

4.1.1. Reference Documents are posted on the CCO Contract Forms Website located at: https://www.oregon.gov/oha/HSD/OHP/Pages/CCO-Contract-Forms.aspx and other webpages expressly referenced in this Contract and are by this reference incorporated into the Contract. OHA may change the CCO Contract Forms Website URL after providing Administrative Notice of such change, with such change to be effective as of the date identified in such Administrative Notice.

All completed Reporting forms must be submitted and, as may be applicable, attested to, by Contractor's Chief Executive Officer, Chief Financial Officer, or an individual who has delegated authority to sign for Reports as designated by the "Delegation Authorization and Signature Form" available on the CCO Contract Forms Website. Contractor shall submit the completed form to OHA, via Administrative Notice, to add or remove an employee with delegated authority and to change the name, contact information, or submission type(s) authorized for a delegated employee.

4.1.2. This Contract is substantially similar to the separate Medicaid Contract that OHA and Contractor have entered into and is based on the template for that separate contract. To minimize redundancy and duplication, this Contract is structured such that for Exhibits A through N hereof, and, as applicable, individual sections within this Contract that are identical to the Medicaid Contract, the corresponding exhibit or section from the Medicaid Contract is incorporated by reference as though fully set forth in such Exhibits or individual sections. In the event an Exhibit or individual section of this Contract does not explicitly refer to the Medicaid Contract, the terms and conditions stated in this Contract shall apply.

4.1.2.1. Where the Medicaid Contract uses the term "Medicaid" to describe services or benefits, such term shall mean, as applied to this Contract, "Medicaid-equivalent services or benefits" since the Members to whom Contractor provides services under this Contract are not eligible for Medicaid and Contractor shall not be paid for services provided under this Contract with any Medicaid Funds.

4.1.2.2. Where the Medicaid Contract refers to "Full Benefit Dual Eligible" or "FBDE," "FBDE Members," "Medicare," "Medicare Advantage," or "Dual Special Needs Plan," Contractor shall disregard the terms and conditions specifically applicable to such populations or payers or both as they are not applicable to this Contract.

4.1.2.3. Pursuant to OAR 410-200-0438, children and adolescents under the age of 19 and AI/AN individuals are not eligible for OHP Bridge – BHP; therefore, they are not covered under this Contract. Accordingly, if this Contract refers, to the provision of Covered Services to children and adolescents under the age of 19 or AI/AN individuals (whether the reference is expressly included in this Contract or inadvertently incorporated by reference back to the Medicaid Contract) Contractor shall disregard the terms and conditions as they apply to such populations.

4.1.2.4. Except as described in Ex. B, Part 2, Sec. 9 or otherwise specifically noted in this Contract, where the Medicaid Contract refers to the provision of Long Term Services and Supports services, which are not, pursuant to OAR 410-115-0030, Covered Services under OHP Bridge - BHP) those terms and conditions are hereby deleted and have no force or effect under this Contract. For avoidance of any doubt, Long Term Services and Supports services are not Covered Services provided to OHP Bridge - BHP Members.

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

4.2. Administration of Contract

OHA has adopted policies, procedures, rules, and interpretations to promote orderly and efficient administration of this Contract and to ensure Contractor's performance. For convenience, OHA has provided in Attachment 1 to these General Provisions the permanent URL for each Oregon Administrative Rule (OAR) and OAR Chapter and Division referenced in this Contract, organized by exhibit, and sorted numerically.

4.3. Interpretation of Contract

In the provision of services required to be performed under this Contract, the Parties shall comply with: (a) all Applicable Laws and regulations and (b) the terms and conditions of this Contract and all amendments thereto that are in effect on the Contract Effective Date or come into effect during the Term of this Contract. To the extent any provision of this Contract incorporates by reference provisions of the Medicaid Contract that references a Medicaid specific federal statute or regulation, the text of such statute or regulation (or both)

shall be deemed incorporated into this Contract and shall be deemed the terms and conditions of this Contract as opposed to an obligation under Applicable Law.

4.3.1. To the extent provisions contained in more than one of the documents listed in Sec. 4.1 above of these General Provisions apply in any given situation, the parties agree: (i) to read such provisions together whenever possible to avoid conflict, and (ii) to apply the order of precedence set forth in Sections 4.3.1.1 and 4.3.1.2 only in the event of an irreconcilable conflict. And, in such event, the conflict will be resolved by considering the version(s) of the provision(s) that was in effect when the appliable event, obligation or action occurred:

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

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

i. Exhibit N: Privacy and Security

ii. Exhibit A: Definitions

iii. Exhibit B: Statement of Work

iv. Exhibit D: Standard Terms and Conditions

v. Exhibit E: Federal Terms and Conditions

vi. Exhibit C: Consideration

vii. Exhibit L: Solvency Plan, Financial Reporting, and Sustainable Rate of Growth

viii. Exhibit I: Grievance and Appeal System

ix. Exhibit G: Reporting of Delivery System Network Providers, Cooperative Agreements, and Hospital Adequacy

x. Exhibit M: Behavioral Health

xi. Exhibit K: Social Determinants of Health and Equity

xii. Exhibit J: Health Information Technology

xiii. Exhibit F: Insurance Requirements

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

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

4.3.2. In the event that the Parties need to look outside of this Contract in order to interpret its terms, the Parties shall follow the order of precedence set forth in OAR 410-141-3501(2), except that references to "OAR Chapter 410, Division 210" shall be replaced with "OAR Chapter 410, Division 115" The sources shall be considered in the form they took at the time the event occurred, or at the time of the obligation or action that gave rise to the need for interpretation.

4.3.3. If Contractor believes that any provision of this Contract or OHA's interpretation thereof is in conflict with federal or State statutes or regulations, Contractor shall promptly notify OHA.

4.3.4. This Contract refers to state and federal laws, rules, and regulations that apply to the federal government's Medicaid program. Such Medicaid Laws apply to and govern the services required to be performed under this Contract for the purposes of establishing the standards, obligations, and rights of the parties.

4.3.5. Except as expressly stated otherwise in this Contract and except for the Services required to be provided to the Member population served under this Contract, where an obligation under this Contract is the same as one set forth in the Medicaid Contract, Contractor shall be deemed to have met the obligation under this Contract if Contractor has met the same obligation under the Medicaid Contract. For purposes of illustration and without limiting Contractor's obligations under this Contract, Contractor's obligations under this Contract that are the same as those under the Medicaid Contract include, without limitation, the following: (i) the obligation to convene a Governing Board under Section 1 of Exhibit B, Part 1; (ii) the obligation to provide Non-Emergent Medical Transportation reports to OHA in accordance with Exhibit B, Part 2; (iii) the obligation to create and implement a Fraud, Waste, and Abuse Prevention Plan and a Fraud, Waste, and Abuse Prevention Handbook under Exhibit B, Part 9; (iv) the obligation to convene a Community Advisory Council under Sections 1 through 4 of Exhibit K to this Contract; (iv) the obligation to create and implement a Grievance and Appeal System and submit deliverables relating thereto under Exhibit I to this Contract; and (v) the obligation to participate in and submit documentation for an annual Mental Health Parity analysis under Section 23 of Exhibit M to this Contract.

4.3.5.1. Contractor shall rely on Exhibit D-Attachment 1 provided with Contractor's Medicaid Contract for every Report where Contractor's obligation is the same in this Contract as that in the Medicaid Contract. Differences in contract citations between this Contract and Exhibit D-Attachment 1 provided with the Medicaid Contract shall be regarded as non-substantive and shall have no effect on Contractor's obligation. Exhibit D-Attachment 1 provided with this Contract shall identify only those Reports where Contractor's obligation is not the same as for the Medicaid Contract.

4.3.5.2. Notwithstanding the foregoing Section 4.3.5.1, in the event that a Report identified in Exhibit D-Attachment 1 of the Medicaid Contract requires Contractor to include in that same Report information specific to this OHP Bridge – BHP Contract, OHA will notify Contractor via Administrative Notice of such requirement at least ninety (90) days before the Report's due date, unless such notice is not possible due to (i) federal or state requirements beyond the control of OHA or (ii) OHA's contractual commitments to a third party whose work is integral to or dependent upon the Report, or both (i) and (ii).

[Remainder of page intentionally left blank]

5. Contractor Data and Certification

Contractor Information. Contractor shall provide the information required as set forth below. This information is requested pursuant to ORS 305.385.

If Contractor is self-insured for any of the Insurance Requirements specified in Ex. F of this Contract, Contractor may so indicate by: (i) writing "Self-Insured" on the appropriate line(s) below; and (ii) delivering, via Administrative Notice, a certificate of insurance as required under Ex. F, Sec. 14.

Please print or type the following information:

Name (exactly as filed with the IRS)

_____

Street Address _____

City, State, Zip Code _____

Telephone _____ Facsimile Number _____

E-mail address: _____

Federal Employer Identification Number (FEIN) _____

Is Contractor a nonresident alien, as defined in 26 U.S.C. § 7701(b)(1)? ☐ YES ☐ NO

Contractor Proof of Insurance:

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

Professional Liability Insurance Co. _____

Policy # _____ Expiration Date _____

Commercial General Liability Insurance Co. _____

Policy # _____ Expiration Date _____

Automobile Liability Insurance Co. _____

Policy # _____ Expiration Date _____

Network Security & Privacy Liability Insurance Co. _____

Policy # _____ Expiration Date _____

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

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

Workers' Compensation Insurance Company _____

Policy # _____ Expiration Date _____

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

Form of Legal Entity: (mark one box)

☐ Professional Corporation
☐ Nonprofit Corporation
☐ Insurance Corporation
☐ Limited Liability Company
☐ Business Corporation

5.1. Certification and Acknowledgement

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

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

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

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

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

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

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

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

5.1.5. The information shown in Sec. 5 of the General Provisions, "Contractor Data and Certification" is Contractor's true, accurate and correct information;

5.1.6. To the best of the undersigned's knowledge after diligent inquiry, Contractor has not discriminated against and will not discriminate against minority, women, or emerging small business enterprises certified under ORS 200.055, in obtaining any required Subcontracts;

5.1.7. Contractor and Contractor's employees and Agents are not included on the list titled "Specially Designated Nationals and Blocked Persons" maintained by the Office of Foreign Assets Control of the United States Department of the Treasury and currently found at: http://www.treasury.gov/resource-center/sanctions/SDN-List/Pages/default.aspx;

5.1.8. Contractor is not listed on the non-procurement portion of the General Service Administration's "List of Parties Excluded from Federal procurement or Nonprocurement Programs" found at: https://www.sam.gov/SAM or such alternative system required for use by Medicaid programs.

5.1.9. Contractor is not subject to backup withholding because:

5.1.9.1. Contractor is exempt from backup withholding;

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

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

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

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

5.3. Signatures

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

«Registered_Name» «Registered_ABN»
By:

Authorized Signature	Printed Name
Title	Date

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

David Inbody, CCO Operations Director	Date

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

Emma Sandoe, PhD, Medicaid Director	Date

Approved as to Legal Sufficiency:
Electronic approval by, Ellen Taussig Conaty Senior Assistant Attorney General, Health and Human Services Section, on 09/18/2024; email in Contract file.

Exhibit A – Definitions

This Ex. A provides definitions for terms used in this Contract that are not defined in the Medicaid Contract. Capitalized terms not defined in this Ex. A have the meanings assigned to them in Ex. A of the Medicaid Contract and such definitions are incorporated by reference as though fully set forth in this Ex. A. The order of precedence for interpreting conflicting definitions for terms used in this Contract is (in descending order of priority):

a. Express definitions in Ex. A of this Contract;

b. Express definitions in Ex. A of the Medicaid Contract;

c. Express definitions elsewhere in this Contract;

d. Definitions in the OARs cited in Ex. A of this Contract; and

e. Definitions in OARs not specifically cited in Ex. A.

For purposes of this Contract, the terms below shall have the following meanings when capitalized. The meanings below shall apply when terms are capitalized. The meanings shall also apply when both capitalized and used:

i. With a possessive case (such as "'s" or "s'"),
ii. In noun form when defined as a verb or vice versa,
iii. In a phrase or with a hyphen to create a compound adjective or noun,
iv. With a participle (such as "-ed" or "-ing"),
v. With a different tense than the defined term,
vi. In plural form when defined as singular and vice versa.

References to "they" when used in the singular or plural tense shall refer to all genders.

Terms not capitalized, whether or not listed below, shall have their commonly understood meaning and usage, including as applicable, the meaning as understood within the health care field and community.

Terms listed below used in this Contract that are not capitalized shall have the meanings listed below when the Parties mutually agree the context determines the term is intended to be used with the defined meaning.

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

"**Contract Year**" means the twelve-month period during the Term that commences on January 1 and runs up to and through the end of the day on December 31 of each calendar year. However, since the Effective Date of this Contract begins after January 1, "Contract Year one" is a truncated period that commences on the Effective Date of July 1, 2024, and run up to and through the end of the day on December 31, 2024.

"Covered Services" has the meaning provided for in OAR 410-115-0005.

"Contract Effective Date" means the date this Contract became effective, as identified in Sec. 1 of the General Provisions of this Contract.

"Medicaid Contract" means the Oregon Health Plan, Health Plan Services Contract, Coordinated Care Organization Contract # «Medicaid_Contract_» awarded to Contractor for Medicaid services in the same Service Area as this Contract as a result of RFA OHA-4690-19, entered into by Contractor and OHA, effective as of October 1, 2019, as may be amended or restated from time to time.

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

"Oregon Health Plan Bridge - Basic Health Program" and **"OHP Bridge - BHP"** each means the Basic Health Program that arose out of Enrolled Oregon House Bill 4035 (2022 Regular session), through which individuals identified in OAR 410-115 are to receive health care in accordance with Section 1331 of the Patient Protection and Affordable Care Act of 2010, 42 CFR Part 600, and OAR Chapters 410 and 309, and any other Oregon Administrative Rules that may be applicable to this Contract.

"OHP Bridge - BHP Members" and **"Members"** each means some or all of the individuals enrolled in the OHP Bridge program and entitled to the services agreed to under this Contract.

"Term" means, notwithstanding ORS 414.590(2)(a) but in accordance with Enrolled Oregon House Bill 2446 (2023), the Term that Contractor is required to provide services to Members under this Contract commencing on July 1, 2024, and expiring, unless earlier terminated or not Renewed in accordance with Sec. 1.2 of the General Provisions and as otherwise provided for in this Contract, December 31, 2026.

[Remainder of page intentionally left blank]

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

1. Governing Board and Governance Structure

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

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

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

(2) For each entity or organization, identify the:

(a) corporate structure, two–character state abbreviation of the state of domicile, and

(b) Federal Employer's Identification Number, and NAIC code for insurers.

(3) A completed Schedule Y of the NAIC Annual Statement Blank—Health is acceptable to supply any of the information required under this Para. b., Sec. 1, of this Ex. B, Part 1.

(4) If any subsidiary or other Affiliate performs business functions for Contractor, describe the functions in general terms.

c. Contractor shall annually provide OHA with a description of Contractor's Governing Board's key committees, including each committee's composition, reporting relationships and responsibilities, oversight responsibility, Monitoring activities, and other activities performed.

d. Contractor shall submit its then-current organizational chart or list as required under Para b. above of this Sec. 1 and its Governing Board and its key committee descriptions as required under Para. c above of this Sec. 1 to OHA, via Administrative Notice, by no later than January 30 of Contract Years two and three.

2. Clinical Advisory Panel

The terms and conditions of Section 2, Exhibit B, Part 1 in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

3. [RESERVED]

4. Innovator Agent and Learning Collaborative

The terms and conditions of Section 4, Exhibit B, Part 1 in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

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

1. Covered Services

The terms and conditions of Section 1, Exhibit B, Part 2 in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

2. Provision of Covered Services

The terms and conditions of Section 2, Exhibit B, Part 2 in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

3. Authorization or Denial of Covered Services

The terms and conditions of Section 3, Exhibit B, Part 2 in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

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

The terms and conditions of Section 4, Exhibit B, Part 2 in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

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

The terms and conditions of Section 5, Exhibit B, Part 2 in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

6. Covered Service Components: Covered Service Components: Preventive Care, Family Planning, Sterilizations & Hysterectomies and Post Hospital Extended Care

The terms and conditions of Section 6, Exhibit B, Part 2 in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

7. Covered Service Component: Medication Management

The terms and conditions of Section 7, Exhibit B, Part 2 in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

8. Covered Service Components: Other Services

a. Care Coordination

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

(2) Contractor shall maintain (CC) policies and procedures that comply with OARs 410-141-3860, 410-141-3865, and 410-141-3870. Contractor shall submit its CC policies and procedures to OHA, via Administrative Notice, for review and approval as follows: (i) by January 31 of each Contract Year; (ii) upon any material change to such policies and procedures; and (iii) within five Business Days of request, as made by OHA from time to time. Contractor shall not implement changes in its CC policies and procedures until approved in writing by OHA. If no changes have been made to Contractor's CC policies and procedures since last approved by OHA, Contractor may, for its annual January 31 submission, submit to OHA via Administrative Notice, an Attestation stating that no changes have been made. OHA will notify Contractor within thirty (30) days from the due date, or within thirty (30) days from the received date if after the due date, of the approval status of its CC policies and procedures; OHA will notify Contractor within the same period if additional time is needed for review. In the event OHA determines Contractor's

CC policies and procedures do not comply with the criteria set forth herein, Contractor shall follow the process set forth in Sec. 5 of Ex. D.

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

b. Tobacco Cessation

Contractor shall provide Culturally and Linguistically Appropriate tobacco dependence Assessments and cessation intervention, treatment, and counseling services. Such services must be provided on a systematic and on-going basis that is consistent with recommendations listed in the Tobacco Cessation standards located at: http://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/TOBACCOPREVENTION/Documents/tob_cessation_coverage_standards.pdf.
Contractor shall make these services available to all Members assessed to use tobacco products including smokeless, dissolvable, electronic vapor, pipes, and cigars. Contractor shall establish a systematic mechanism to document and report dependency and cessation services. Contractor may refer to accepted published Evidence-Based Community Standards, the national standard, or as set forth under OAR 410-130-0190.

c. [RESERVED].

d. Oral Health Services

(1) Contractor shall provide to Members all Oral Health Covered Services within the scope of the Member's Benefit Package of Dental Services, in accordance with the terms of this Contract and as set forth in OAR Chapter 410, Division 141 applicable to Dental Care Organizations.

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

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

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

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

Oral Health stakeholders may include dental providers, Subcontracted Dental Care Organizations, and other similarly interested third-parties.

e. Telehealth Services

Contractor shall ensure that Telehealth services meet all applicable requirements of OAR 410-141-3566[1], including requirements relating to Telehealth reimbursement, service delivery, patient choice and consent, access to care, and compliance with federal and state privacy and confidentiality rules.

9. Non-Covered Health Services with Care Coordination

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

a. Except as provided in Sec. 10 below of this Ex. B, Part 2, Contractor shall coordinate services for each Member who requires health services not covered under this Contract. Such services not covered include, but are not limited to, the following:

(1) Out-of-Hospital birth (OOHB), also known as Planned Community Birth (PCB), services including prenatal and postpartum care for individuals meeting criteria defined in OAR 410-130-0240. Specifically, OHA will be responsible for providing and paying for Care Coordination related to maternity care and primary OOHB services for those Members approved for OOHBs as well as for those Members in provisionally approved status. Further, OHA will be responsible for providing and paying for newborn initial assessment and newborn bloodspot screening test, including the screening kit obtained through Oregon State Public Health Laboratory. OHA will also be responsible for, with the assistance of Contractor, providing Care Coordination for the services ancillary to OOHBs including, but not limited to, pharmacy, ultrasounds, labs, prenatal vitamins, and all other Covered Services related to typical maternity care. However, Contractor shall be responsible for payment of the foregoing typical ancillary maternity care services and continue to be responsible for providing Care Coordination and payment of Covered Services other than those related to maternity care. OHA shall provide Contractor with a list of Members approved and not approved for OOHB services on a regular basis;

(2) [RESERVED]

(3) Family Connects Oregon services, notwithstanding exclusion from Contractor reimbursement.

b. Contractor shall assist its Members in gaining access to certain Behavioral Health services that are Carve-Out Services, including but not limited to the following:

(1) Mental health drugs specified in OAR 410-141-3855[2] that include but are not limited to standard therapeutic class 7 & 11 Prescription Drugs, Depakote, Lamictal and their generic equivalents dispensed through a licensed pharmacy. These medications are paid through OHA's Fee for Service system;

(2) [RESERVED]

[1] The CCO-specific telehealth rule at OAR 410-141-3566 will be repealed effective 1/1/2025. It will be replaced with the FFS telehealth rule at OAR 410-141-1990, which will be revised to incorporate CCO-specific requirements.
[2] This existing OAR may be updated prior to 1/1/2025 to add a new carved-out mental health drug.

(3) [RESERVED];

(4) Investigation of Members for Civil Commitment;

(5) [RESERVED];

(6) [RESERVED];

(7) [RESERVED];

(8) [RESERVED];

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

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

(11) [RESERVED]; and

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

10. Non-Covered Health Services without Care Coordination

Contractor must provide information in its Member Handbook about the availability of support from OHA or its designee to access Non-Covered Health Services without Care Coordination described in this Para. a. of Sec. Additionally, Contractor is responsible for ensuring its Members have access to NEMT services for the services described in this Para. a. of Sec. 10. Non-Covered Services for which Contractor is not required to provide Care Coordination include, but are not limited, to:

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

b. [RESERVED];

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

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

e. Abortions.

11. In Lieu of Services (ILOS)

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

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

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

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

Procedure codes: H0038, H2014, H2016, T1016.
Modifier(s): V4 (ILOS-specific modifier for tracking purposes), GQ.

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

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

(2) Community Health Worker Services - Alternative Setting

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

Procedure codes: 99211, 99401-99404, H2014, H2016.
Modifier(s): V4 (ILOS-specific modifier for tracking purposes).

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

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

(3) Online Diabetes Self-Management Programs

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

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

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

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

(4) *Service Description:* Online training, support, and guidance provided by a health coach in synchronous or asynchronous individual or group sessions aimed at assisting a Member in controlling their daily blood glucose levels, managing their diabetes, and engaging in preventive health habits. **National Diabetes Prevention Program - Alternative Setting**

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

Procedure codes: 0403T, 0488T.

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

Target Population: Members 19 years of age or older who have a body mass index of 25 or higher (23 or higher if Asian American), not previously diagnosed with type 1 or type 2 diabetes, and not pregnant.

(5) *Service Description:* Provision of the National Diabetes Prevention Program (National DPP) by a Centers for Disease Control and Prevention (CDC) recognized program delivery organization. **Chronic Disease Self-Management Education Programs - Alternative Setting**

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

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

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

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

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

(6) [RESERVED]

(7) Lactation Consultations – Alternative Setting

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

Procedure codes: 99202, 99212, 99401-99404.

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

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

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

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

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

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

Service Description: Office or other outpatient visit for evaluation and management of a Member who may be a new or established patient. Preventive medicine counseling or risk factor reduction interventions provided to a Member. High intensity behavioral counseling to prevent sexually transmitted infection, which may: (i) be provided individually and face-to- face and (ii) include education, skills training, and guidance on how to change sexual behavior, and (iii) be performed semi-annually, 30 minutes. The testing and treatment may involve venipuncture. Services to be provided by a registered nurse, physician's assistant, nurse practitioner, or physician in community settings, such as Local Public Health Authority clinics, community-based agency clinics, or testing events, or any combination thereof.

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

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

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

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

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

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

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

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

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

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

(11) Climate Supports & Services – Alternative Population

State Plan Service(s) In Lieu of: Acute outpatient or inpatient care for climate-related exacerbation of certain conditions, or treatment of climate-related adverse health events.

Procedure Codes: S5165, T2028, T2029.

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

Target Population:

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

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

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

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

(12) Indicated Preventive Behavioral Health Services

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

Procedure Codes: 90832-90837, 90846-90847, 90849, 90853, 97153-97154, 97156-97157, H0038, H0046, H2014, H2019-H2020, H2027, H2037, H2038, T1016.

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

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

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

(13) Mobile Integrated Health Services – Community Services

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

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

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

Target Population: Members with health-related social needs that limit and/or prevent access to care and effective treatments, including but not limited to (i) Members experiencing houselessness, (ii) Members with barriers to transportation, (iii) Members living alone or with social isolation, or (iv) Members who are seasonal/migrant laborers; Members diagnosed with chronic physical or behavioral conditions; Members with previous trauma from a clinical setting; Members in need of preventive services such as not but not limited to vaccine administration.

Service Description: Mobile integrated health provided to a Member in a community setting or residence of the Member. Services may include: preventive supports, chronic condition support and treatment, care coordination, wraparound support, vaccine administration, post-discharge supports and services, transitional care management, peer services, mental and behavioral health services or telehealth appointment set-up assistance. Contractor is not required to offer ILOS to Members. Notwithstanding the foregoing, Contractor shall consider using alternative services including ILOS and Health-Related Services when such use could improve a Member's health or resource efficiency (or both).

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

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

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

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

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

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

h. Contractor may add or remove ILOS annually.

(1) Prior to removal of an ILOS, Contractor shall ensure that no Member who has been authorized to receive an ILOS has their ILOS disrupted by the change by either permitting such Member to complete the authorized service or by seamlessly transitioning the Member to another Medically Appropriate service or program that adequately meets the Member's needs.

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

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

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

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

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

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

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

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

12. [RESERVED]

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

a. Contractor shall meet the following requirements relating to Early and Periodic Screening, Diagnostic, and Treatment services for Members age 19 to 21:

(1) *Informing requirements:*

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

(i) The benefits of preventive health care;

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

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

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

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

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

(2) *Screening requirements:* Contractor shall provide and pay for EPSDT screening services identified in OAR Chapter 410, Division 151, consistent with Ex. B, Part 2, Sec. 6 and in accordance with the periodicity schedule specified in the applicable guideline note in the Prioritized List for screenings other than Oral Health. The periodicity schedule for Oral Health screening is available on OHA's OHP Dental Services Program webpage (https://www.oregon.gov/oha/HSD/OHP/Pages/Policy-Dental.aspx).

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

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

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

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

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

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

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

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

b. In addition to requirements specified in Para. a above and consistent with Section 7 of Enrolled Oregon Senate Bill 1557 (2024), Contractor shall ensure that Members age 19 and 20 (up to their 21st birthdate) have timely access to:

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

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

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

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

14. [RESERVED]

15. [RESERVED]

16. [RESERVED]

17. [RESERVED]

[Remainder of page intentionally left blank]

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

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

The terms and conditions of Section 1, Exhibit B, Part 3 in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

2. Member Rights and Responsibilities

The terms and conditions of Section 2, Exhibit B, Part 3 in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

3. Provider's Opinion

The terms and conditions of Section 3, Exhibit B, Part 3 in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

4. Informational Materials for Members and Potential Members: General Information and Education

The terms and conditions of Section 4, Exhibit B, Part 3 in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

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

The terms and conditions of Section 5, Exhibit B, Part 3 in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

6. Informational Materials for Members and Potential Members: Provider Directory

The terms and conditions of Section 6, Exhibit B, Part 3 in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

7. Grievance and Appeal System

The terms and conditions of Section 7, Exhibit B, Part 3 in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

8. Enrollment

a. An individual becomes a Member for purposes of this Contract in accordance with OAR Chapter 410, Division 115 and OAR 410-200-0015 as of the date of Enrollment with Contractor. As of the date of Enrollment, Contractor shall provide all Covered Services to such Member as required by the terms of this Contract.

b. The provisions of this Sec. 8, Ex. B, Part 3 apply to all Enrollment arrangements as specified in OAR 410-141-3805. OHA will enroll a Member with the CCO selected by the Member. If an eligible Member does not select a CCO, OHA may assign the Member to a CCO selected by OHA in accordance with 42 USC § 1396u-2(a)(4)(D). Contractor shall accept, without restriction, all eligible Members in the order in which they apply and are Enrolled with Contractor by OHA, unless Contractor's Enrollment is closed as provided for Para. d of this Sec. 8, Ex. B, Part 3.

c. Contractor shall not discriminate against individuals eligible to Enroll, nor Disenroll, on the basis of health status, the need for health services, race, color, national origin, religion, sex, sexual orientation, marital status, age, gender identity, or disability and shall not use any policy or practice that has the effect of discriminating on the basis of such foregoing characteristics or circumstances.

d. Enrollment with Contractor may be closed by: (i) OHA upon Administrative Notice to Contractor's Contract Administrator, or (ii) by Contractor upon Administrative Notice to OHA's

designated OHA CCO Coordinator, if and when Contractor's maximum Enrollment has been reached, or for any other reason mutually agreed to by OHA and Contractor, or as otherwise authorized under this Contract or OAR 410-141-3805.

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

f. If OHA Enrolls a Member with Contractor in error and the Member has not received services from another CCO, OHA will apply the Disenrollment rules in OAR 410-141-3810 and may retroactively Disenroll the Member from Contractor and enroll the Member with the originally intended CCO up to sixty (60) days from the date of the erroneous Enrollment, and the CCO Payment to Contractor will be adjusted accordingly.

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

h. Contractor shall actively support Full Benefit Dual Eligible (FBDE) Member enrollment decisions by providing information about opportunities to align and coordinate Medicaid benefits with Contractor's Affiliated or Contracted Medicare Advantage or Dual Special Needs Plan. This includes ensuring newly Medicare eligible members receive information about the affiliated Medicare Advantage or Dual Special Needs Plan at least sixty (60) days prior to the Medicare effective date.

i. Contractor shall actively support enrollment transition of Members to ensure the highest level of coverage for physical health, Behavioral Health, and Oral Health services, as relevant.

9. Disenrollment

The terms and conditions of Section 9, Exhibit B, Part 3 in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

10. Member Benefit Package Changes

The terms and conditions of Section 10, Exhibit B, Part 3 in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

11. Enrollment Reconciliation

The terms and conditions of Section 11, Exhibit B, Part 3 in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

12. Identification Cards

The terms and conditions of Section 12, Exhibit B, Part 3 in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

13. Marketing to Potential Members

The terms and conditions of Section 13, Exhibit B, Part 3 in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

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

1. Integration and Coordination

The terms and conditions of Section 1, Exhibit B, Part 4 in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

2. Access to Care

Contractor shall provide Culturally and Linguistically Appropriate Services and supports in locations as geographically close as possible to where Members reside or seek services. Contractor shall also provide a choice of Providers (including physical health, Behavioral Health, Providers treating Substance Use Disorders, and Oral Health) who are able to provide Culturally and Linguistically Appropriate Services within the Delivery System Network that are, if available, offered in non-traditional settings that are accessible to Families, diverse Communities, and underserved populations.

a. Contractor shall meet, and require all Providers to meet, OHP standards for timely access to care and services, taking into account the urgency of need for services. Contractor shall comply with OAR 410-141-3515. Contractor shall make Covered Services available twenty-four (24) hours a day, seven (7) days a week, when Medically Appropriate as set forth in OAR 410-141-3515

(1) For Members requiring Medication Assisted Treatment (MAT), Contractor shall:

(a) Assist such Members in navigating the health care system and utilize Community resources such as Hospitals, Peer Support Specialists, and the like, as needed until assessment and induction can occur;

(b) Ensure Providers provide interim services daily until assessment and induction can occur and barriers to medication are removed. Such daily services may include utilizing the Community resources identified in Sub. Para. (4)(a) above of this Para. a, Sec. 2, Ex. B, Part 4 or other types of Provider settings. In no event shall Contractor or its Provider require Members to follow a detox protocol as a condition of providing such Members with assessment and induction;

(c) Provide such Members with an assessment that includes a full physical as well as a bio-psycho-social spiritual assessment and prescribe and deliver any necessary medication taking into consideration the results of such assessment and also the potential risks and harm to the Member in light of the presentation and circumstances; and

(d) Provide no less than two (2) follow up appointments to such Members within one (1) week after the assessment and induction.

(2) For Members with Special Health Care Needs or receiving Long Term Services and Supports determined through an assessment to need a course of treatment or regular care Monitoring (regardless of whether Contractor is paying for the Member to receive such services under this Contract) Contractor shall have a mechanism in place to allow Members to directly access a Specialist (for example, through a standing Referral or an approved number of visits), as appropriate for the Member's condition and identified needs. Contractor shall ensure the services supporting Members with ongoing or chronic conditions, or who require Long-Term care and Long Term Services and Supports, are authorized in a manner that reflects each such Member's ongoing need for such services and supports and does not create a burden to Members who need medications or services to appropriately care for chronic conditions; and

(3) Regardless of whether Contractor is paying for the Member to receive such services under this Contract, Contractor shall have policies and mechanisms for producing, in consultation with the appropriate Providers, including Medicare Providers, an integrated treatment or care plan, or transition of care plan for Members:

(a) With Special Health Care Needs,

(b) Receiving Long Term Services and Supports,

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

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

(e) Who are receiving Home and Community Based Services for Behavioral Health conditions, and

(f) FBDE Members enrolled in Contractor's Affiliated MA or Dual Special Needs Plans in order to meet CMS goals for reducing duplication of assessment and care planning activities for improved coordination and Member outcomes.

b. Report the barriers to access to care for such Members and draft a strategic plan for removing such barriers. Such Report and strategic plan must be provided to OHA upon request. Contractor may request technical support from OHA to assist with the efforts required hereunder.

c. For routine Oral Health care Members shall be seen within eight (8) weeks, unless there is a documented, special clinical reason which would require longer access time. Pregnant individuals shall be provided Oral Health care according to the timelines outlined in OAR 410-123-1510.

d. Contractor shall ensure that Providers do not discriminate between Members and non-OHP persons with respect to benefits and services to which they are both entitled and shall ensure that Providers offer hours of operation to Members that are no less than those offered to non-Members as provided in OAR 410-141-3515.

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

f. Contractor does not have the right to, and shall not, deny Covered Services to, or request Disenrollment of, a Member based on disruptive or abusive behavior resulting from symptoms of a mental or Substance Use Disorders or from any other disability. Contractor shall develop appropriate Treatment Plans with such Members and their Families or advocates to manage such behavior.

g. Contractor shall implement mechanisms to Assess each Member with Special Health Care Needs and Members receiving Long Term Services and Supports (regardless of whether Contractor is paying for the Member to receive such services under this Contract) in order to identify any ongoing special conditions that require a course of physical health, Behavioral Health services, or care management, or all or any combination thereof. The Assessment mechanisms must use appropriate health care professionals. For those Members with Special Health Care needs and Members receiving Long Term Services and Supports who are determined to need a course of treatment or regular care Monitoring (regardless of whether Contractor is paying for the Member to receive such services under this Contract), Contractor shall:

(1) Develop and implement a written Care Plan. Each Member's Care Plan must be: (i) developed by the entity designated as primarily responsible for coordinating such services, with Member participation and in consultation with any Providers and Specialists caring

for the Member; (ii) approved by Contractor in a timely manner; and (iii) revised upon Assessment of function, need, or at the request of the Member. Such Care Plan revisions must be made in accordance with OARs 410-141-3865 and 410-141-3870. All Care Plans must be developed in accordance with any applicable OHA quality Assessment and performance improvement and Utilization Review standards;

(2) Assist such Members in gaining direct access to Medically Appropriate care from physical health or Behavioral Health Specialists, or both, for treatment of the Member's condition and identified needs including the assistance available through the entity designated as primarily responsible for coordinating such Member's services, if appropriate; and

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

h. Contractor shall comply with the requirements of Title III of the Americans with Disabilities Act Title VI of the Civil Rights Act, and Section 1557 of the ACA by assuring communication and delivery of Covered Services to Members with diverse cultural and ethnic backgrounds. Contractor shall, in order to ensure the communication about, and delivery of, Covered Services in compliance with such Acts, provide, without limitation:

(1) Certified or Qualified Health Care Interpreter services for those Members who have difficulty communicating due to a medical condition, a disability, or have limited English proficiency; or

(2) Auxiliary aids and services when no adult is available to communicate in English or Certified or Qualified Health Care Interpreters cannot be made available by telephone.

i. Contractor shall maintain written policies, procedures, and plans relating to the communication about, and delivery of Covered Services in compliance with Para. h above of this Section in accordance with the requirements of OAR 410-141-3515.

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

k. Contractor shall ensure that its employees, Subcontractors, and facilities are prepared to meet the special needs of Members who require accommodations because of a disability or limited English proficiency. Contractor shall include in its Grievance and Appeal procedures, described in Ex. I, a process for Grievances and Appeals concerning communication or access to Covered Services or facilities.

l. Contractor shall develop and implement civil rights policies and procedures that comply with 45 CFR §92.8. Contractor shall provide its relevant employees and Subcontractors with training on its civil rights policies and procedures required by 45 CFR § 92.8 as is necessary for the employees and Subcontractors to carry out their job responsibilities and functions. The foregoing training must be in compliance with 45 CFR §92.9 and this Sec. 2 and any other applicable provisions of this Contract.

m. In addition to access and Continuity of Care standards specified in the rules cited in Para. a, of this Sec. 2, Ex. B, Part 4, Contractor shall develop a methodology for evaluating access to Covered

Services as described in Sec. 1, Ex. G of this Contract and Continuity of Care which are consistent with the Accessibility requirements in OARs 410-141-3515, 410-141-3860, 410-141-3865, and 410-141-3870.

n. Contractor shall ensure that each Member has an ongoing source of primary care appropriate to the Member's needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished as described in OAR 410-141-3860, 410-141-3865, and 410-141-3870 and as required by 42 CFR 438.208 (b)(1) and (2).

(1) In accordance with Enrolled Oregon Senate Bill 1529 (2022), Contractor must allow a Member to choose a new PCP at any time.

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

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

p. Contractor shall provide female Members with direct access to women's health Specialists within the Provider Network for Covered Services necessary to provide women's routine and preventive health care services. This is in addition to the Member's designated PCP if the designated PCP is not a women's health Specialist.

q. Contractor shall provide for a second opinion from a Participating Provider, which may include, if appropriate, a Participating Behavioral Health Provider to determine Medically Appropriate services. If a Participating Provider cannot be arranged then Contractor shall arrange for the Member to obtain the second opinion from a Non-Participating Provider, at no cost to the Member.

r. [RESERVED]

s. In the event Contractor is unable to provide local access to care by Health Care Professionals or other Providers sufficiently qualified and specialized to treat a Member's condition, it must demonstrate such inability and provide reasonable alternatives to care in accordance with OAR 410-141-3515.

t. Contractor shall ensure that a Provider:

(1) Complies with the requirements of Enrolled Oregon House Bill 2359 (2021) regarding OHA's health care interpreter registry, language proficiency requirements for bilingual Providers, and documentation of all interpreter services including good faith efforts to work with OHA Qualified or Certified Health Care Interpreters before working with an interpreter who is not listed on OHA's interpreter registry;

(2) Works with a Certified Health Care Interpreter or a Qualified Health Care Interpreter when interacting with Member, or a caregiver of a Member, who has limited English proficiency or who communicates in signed language; and

(3) Is reimbursed for the cost of the interpreter.

u. Contractor shall, as required by and in accordance with the applicable deadlines set forth in OAR 410-141-3515, submit (i) the annual interpreter services self-assessment and (ii) the quarterly language access and interpreter services reports to OHA via Administrative Notice.

(1) Contractor shall use the language access and interpreter services reporting template provided by OHA on the CCO Contract Forms Website.

(2) Contractor shall complete and submit the interpreter services self-assessment by entering the information into a web-based portal; OHA will provide Contractor, via Administrative Notice, with information about how to access the portal. OHA will provide Contractor with a reference copy of the self-assessment so that Contractor may preview the requested information prior to entering it into the portal. Such reference copy will be posted on the CCO Contract Forms Website.

v. Contractor shall ensure that any phone numbers that Members and Potential Members are directed to use to contact Contractor are answered by a phone system that meets the following requirements:

(1) The message played when the phone system answers a call must, at a minimum, be in English and Spanish. Contractor may elect to include one or more other languages. The system instructions in each language must clearly and accurately explain to the caller how to navigate the system. The instructions in each language must clearly explain what the caller should do if they speak a language other than English, including how to request an interpreter.

(a) Contractor may choose to establish a dedicated queue within its phone system for non-English speaking callers. In such cases, the initial phone system message must clearly and accurately explain, at a minimum, in English and Spanish and, as applicable, any other language(s) elected by Contractor, how to access this queue. Once connected to the dedicated queue, the instructions must be in Spanish and, as applicable, the other language(s), and clearly and accurately explain to the caller how to navigate the system.

(2) If the phone system does not provide the opportunity for the caller to identify their non-English language prior to connecting the call to a live representative, then, prior to connecting the call, the system instructions must advise the caller of this fact and further advise them to state their need for an interpreter and identify their non-English language when the call is answered.

(3) If the phone system provides the opportunity for the caller to identify their non-English language prior to connecting the call to a live representative, then the call must be answered by either (i) a representative who speaks the caller's non-English language or (ii) a representative who already has an interpreter on the call who speaks the caller's non-English language.

w. Contractor shall comply with the requirements related to the minimum and maximum number of allowable visits for doula services specified in OAR Chapter 410, Division 130.[3]

3. Delivery System and Provider Capacity

The terms and conditions of Section 3, Exhibit B, Part 4 in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

4. Provider Selection

[3] This existing OAR will be updated effective 1/1/2025.

The terms and conditions of Section 4, Exhibit B, Part 4 in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

5. Credentialing

The terms and conditions of Section 5, Exhibit B, Part 4 in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

6. Patient Centered Primary Care Homes

a. Contractor shall include in its network, to the greatest extent possible, Patient-Centered Primary Care Homes as identified by OHA. Contractor shall develop and assist in advancing Providers along the spectrum of the PCPCH model (from Tier 1 to Tier 5). Contractor shall assist Providers within its delivery system to establish PCPCHs.

b. In addition to the Provider reporting requirements required under this Contract and Applicable Law, Contractor shall provide OHA with an annual Report with facility-level data about all Members who are assigned to a PCPCH Provider. Such annual Report shall be provided to OHA, via Administrative Notice, within thirty (30) days after the end of the reporting Contract Year. OHA will provide Contractor with timely special instructions regarding the Administrative Notice submission process required to be used for submitting the annual PCPCH Report. The Report about Members who were assigned to a PCPCH Provider during Contract Year two (2025) shall be due by no later than January 30, 2026. Contractor shall coordinate with each PCPCH Provider in developing these lists and the report shall list facility-level data about all such Members by tier levels 1, 2, 3, 4, or 5. In addition to the Reporting obligations under this Para. b, Sec. 6, Ex. B, Part 4, OHA reserves the right to require Contractor to provide Member-level PCPCH enrollment data as may be specified otherwise in this Contract.

c. Contractor shall require its Providers to communicate and coordinate care with the PCPCH in a timely manner using electronic health information technology to the maximum extent feasible.

d. Contractor shall develop and use PCPCH and other patient-centered primary care approaches to achieve the goals of Health System Transformation.

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

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

(1) Encourage the use of FQHCs, rural health clinics, school-based health clinics and other safety net Providers that qualify as PCPCHs to ensure the continued critical role of those Providers in meeting the health of underserved populations;

(2) Negotiate a rate of reimbursement with FQHCs and RHCs that is not less than the level and amount of payment which Contractor would make for the same service(s) furnished by a Provider which is not a FQHC or RHC, consistent with the requirements of 42 USC § 1396b (m)(2)(A)(ix) and Section 4712(b)(2) of the Balanced Budget Act of 1997;

7. Indian Health Care Providers

a. With respect to Indian Health Care Providers (IHCPs), Contractor shall:

(1) Offer contracts to all Medicaid eligible IHCPs in its Service Area, offering reimbursement at the same IHS or PPS encounter rate, as applicable to the specific IHCP, that OHA would pay the IHCP if billed to OHA for a FFS Member;

(2) Provide CCO-enrolled Indian Health Services beneficiaries who have been seen and referred by IHCPs with access to specialty and primary care within Contractor's Provider Network. The CCO-enrolled Indian Health Services beneficiaries must be provided with such access regardless of whether a referring IHCP is one of Contractor's Network Providers ;

(3) [RESERVED]

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

(a) If Contractor and IHCP do not reach an agreement on the terms of the contract within six months, the IHCP may request the assistance of a State representative to assist with negotiation of the contract.

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

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

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

8. Care Coordination

Contractor shall provide all of the elements of Care Coordination as set forth below in this Sec. 8, Ex. B, Part 4 and in accordance with OARs 410-141-3860, 410-141-3865, and 410-141-3870.

a. [RESERVED]

b. Contractor shall use Evidence-Based and innovative strategies within Contractor's delivery system to ensure coordinated and integrated person-centered care for all Members, including those with severe and persistent mental illness, Special Health Care Needs, or other chronic conditions, who, if known, receive Home and Community-Based services under the 1915(i) State Plan Amendment, or any Long Term Services and Supports through ODHS (regardless of whether Contractor is paying for the Member to receive such services under this Contract) as follows:

(1) Assignment of responsibility and accountability: Contractor shall document that each Member has a PCP or primary care team that is responsible for coordination of care and Care Setting Transitions;

(2) Individual care plans: Contractor shall use individualized care plans to address the supportive and therapeutic and cultural and linguistic health of each Member.Contractor shall ensure that individual care plans developed for Members reflect Member, Family, or caregiver preferences and goals to ensure engagement and satisfaction; and

(3) Communication: Contractor shall encourage and work with their Providers to develop the tools and skills necessary to communicate in a Culturally and Linguistically Appropriate fashion and to integrate the use of HIE and event notification.

9. Care Integration

The terms and conditions of Section 9, Exhibit B, Part 4 in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

10. Delivery System Dependencies

a. State and Local Government Agencies and Community Social and Support Services Organizations

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

b. Cooperation with Dental Care Providers

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

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

Contractor shall arrange to provide medication, as covered under Contractor's Global Budget, to Members located in nursing or residential facilities, and in group or foster homes. All medications shall be provided in a format that is reasonable for each facility, including the manner of delivery, dosage, and packaging requirements and as permitted under State and federal law. Contractor shall ensure Members in Nursing Facilities, Foster Care, Group Homes and other similar residential settings have access to and are provided with all medically necessary services provided by Contractor under this Contract, including, without limitation, oral care and Behavioral Health Assessments, by collaborating and coordinating with such facilities.

11. Evidence-Based Clinical Practice Guidelines

The terms and conditions of Section 11, Exhibit B, Part 4 in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

12. Subcontract Requirements

The terms and conditions of Section 12, Exhibit B, Part 4 in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

13. Minority-Owned, Woman-Owned and Emerging Small Business Participation

The terms and conditions of Section 13, Exhibit B, Part 4 in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

14. Adjustments in Service Area or Enrollment

The terms and conditions of Section 14, Exhibit B, Part 4 in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

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

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Exhibit B – Statement of Work – Part 8 – Accountability and Transparency of Operations

1. Record Keeping Requirements

The terms and conditions of Section 1, Exhibit B, Part 8 in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

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

The terms and conditions of Section 2, Exhibit B, Part 8 in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

3. Access to Records

The terms and conditions of Section 3, Exhibit B, Part 8 in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

4. Payment Procedures

a. Contractor shall pay for all Covered Services to Members and may require, except in the event of Emergency Services, that Members obtain such Covered Services from Contractor or Providers Affiliated with Contractor in accordance with OAR 410-141-3520.

b. Contractor understands and agrees that neither OHA nor the Member receiving services are liable for any costs or charges related to Contractor-authorized Covered Services rendered to a Member whether in an emergency or otherwise, including holistic care.

c. Except as specifically permitted by this Contract (e.g., Third Party Resource recovery), Contractor will not be compensated for Work performed under this Contract from any other agency, division, or department of the State, nor from any other source including the federal government.

d. Contractor shall comply with Section 6507 of the ACA regarding the use of National Correct Coding Initiative.

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

f. Consistent with 42 CFR § 438.106 and 42 CFR § 438.230, Contractor shall prohibit Subcontractors, including Providers, from billing Members for Covered Services in any amount greater than would be owed if Contractor provided the services directly. Additionally, Contractor and its Providers shall comply with OAR 410-120-1280 relating to when a Provider may bill a Medicaid recipient and when a Provider may send a Medicaid recipient to collections for unpaid medical bills.

g. Contractor's Providers shall not bill a Member for Non-Covered Services unless the Provider complied with the requirements set forth OAR 410-120-1280(5)(h) prior to providing any of the Non-Covered Services.

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

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

5. Claims Payment

a. Claims that are subject to payment under this Contract by Contractor for services provided by Non-Participating Providers who are enrolled with OHA will be billed to Contractor consistent with the requirements of OAR 410-120-1280, 410-120-1295,[4] and 410-120-1300. Contractor shall pay Non-Participating Providers for Covered Services, consistent with the provisions of ORS 414.743, OAR 410-120-1295(2), OAR 410-120-1340, and OAR 410-141-3565.[5]

b. Pursuant to OAR 410-141-3565, Contractor shall require Providers to submit all claims for Members to Contractor within 120 days of the Date of Service. However, Providers may, if necessary, submit their claims to Contractor within 365 days of the Date of Service under the following circumstances:

(1) Billing is delayed due to retroactive deletions or enrollments;

(2) Pregnancy of the Member;

(3) Medicare is the primary payer, unless Contractor is responsible for Medicare reimbursement;

(4) Cases involving Third Party Resources; or

(5) Other cases that delay the initial billing to Contractor, unless the delay was due to the Provider's failure to verify a Member's eligibility.

c. Contractor shall have written policies and procedures for processing claims submitted for payment from any source. The policies and procedures must specify time frames for and include or require (or both) all of the following:

(1) Date stamping claims when received;

(2) Determining within a specific number of days from receipt whether a claim is Valid or invalid;

(3) The specific number of days allowed for follow up of pended claims to obtain additional information;

(4) The specific number of days following receipt of additional information to determine whether a claim is Valid or invalid;

(5) Sending notice to the Member regarding Contractor's decision regarding the denial of a claim, in whole or in part, of payment for a service rendered which must include information on the Member's Grievance and Appeal rights;

(6) Making information about a Member's Grievance and Appeal rights available upon request to a Member's authorized Member Representative who may be either a Participating Provider or a Non-Participating Provider when the determination is made to deny a claim, in whole or in part, of payment for a service rendered; and

[4] This existing OAR will be updated effective 1/1/2025.
[5] This existing OAR will be updated effective 1/1/2025

(7) The date of payment, which is the date of the check or date of other form of payment.

d. Contractor shall establish a timeframe in its written policies and procedures allowing Providers to make re-submissions or appeals for a minimum of one hundred eighty (180) days after the initial adjudication date under the following circumstances:

(1) The initial claim was timely submitted and needs correction;

(2) The initial claim has prompted a Provider appeal pursuant to OAR 410-120-1560; or

(3) Any other reason not included in Para. b above in this Ex. B, Pt. 8, Sec. 5 that would otherwise require a re-submission of the claim.

e. In accordance with 42 CFR § 447.45 and 42 CFR § 447.46, Contractor shall pay or deny at least ninety percent (90%) of Valid Claims within thirty (30) days of receipt and at least ninety-nine percent (99%) of Valid Claims within ninety (90) days of receipt. Contractors shall make an initial determination on ninety-nine percent (99%) of all Valid Claims submitted within sixty (60) days of receipt. The Date of Receipt of a Claim is the date Contractor receives a claim, as indicated by its date stamp thereon. Contractor and its Subcontractors may, by mutual agreement, agree to a different payment schedule provided that the minimum requirements required under 42 CFR § 447.45 and 42 CFR § 447.46 are met.

f. If a Non-Participating Provider who is enrolled with OHA is entitled to payment from Contractor for services provided to a Member, the Non-Participating Provider must bill Contractor in accordance with the requirements set forth in OAR 410-120-1280 and 410-120-1300. If a Provider is not enrolled with OHA on the Date of Service, but the Provider subsequently becomes enrolled pursuant to OAR 410-120-1260(6) Contractor shall process such claim as a claim from a Non-Participating Provider. Payment to Non-Participating Providers shall be consistent with the provisions of OAR 410-120-1340.

g. Contractor shall pay Indian Health Care Providers for Covered Services provided to those Members who are eligible to receive services from such Providers. Payment to IHCPs for Covered Services shall be made as follows:

(a) At the same IHS or PPS encounter rate, as applicable to the specific IHCP, that OHA would pay the specific IHCP if such IHCP billed OHA for providing the services to a Medicaid FFS Member; and

(b) For services not eligible for the IHS or PPS encounter rate, a rate that is not less than the level and amount that Contractor would make for the services if the services were furnished by a Participating Provider that is not an IHCP.

(c) For the purpose of clarity, with respect to Covered Services provided to all BHP Members, Contractor must pay IHCPs at a rate that is no less than the IHS or PPS encounter rate for those Covered Services that are potentially eligible for the encounter rate under Contractor's separate Medicaid Contract. "Potentially eligible" claims become eligible claims that must be paid to IHCPs at a rate that is no less than the IHS or PPS encounter rates when they not on the PPS exclusion list and the Member is either (i) AI/AN, regardless of whether Contractor has a contract with the IHCP, or (ii) is not AI/AN and Contractor does have a contract with the IHCP.

h. The Parties acknowledge that the IHCP IHS and PPS encounter rates for each calendar year are established by the federal government and announced to the public on a schedule that may not align with the calendar year cycle. Upon the federal government's publication of the calendar year's new rates, Contractor shall promptly (i) update its systems with the new rates and (ii) pay all eligible IHCP claims at the applicable new rate. The obligation to pay all eligible claims at the new rates includes reprocessing previously paid claims in order to make the IHCP whole at the new rate for the calendar year. Contractor shall undertake such retroactive activity and make any required, subsequent payments that may arise as a result of any encounter rate changes without regard to the IHCP's Network Provider status and without requiring any IHCP to initiate claims reprocessing or payment at the applicable new rate. Contractor shall timely pay IHCPs at the then-current rates and must not delay or otherwise hold-back payment to IHCPs in anticipation of the federal government's publication of the new rates for the calendar year. In accordance therewith, Contractor shall not condition payment of the IHCP rate for the new calendar year on the execution of any contract amendment by its Participating IHCPs, unless the IHCP indicates that it no longer wishes to contract at the encounter rate.

i. Contractor shall make prompt payment to IHCPs including Indian Tribes, Tribal Organizations, or Urban Indian Organizations, in the same time frame required under Para. e above of this Sec. 5, Ex. B, Part 8.

j. In accordance with Section 5006 of the American Reinvestment and Recovery Act of 2009, Contractor shall not impose fees, premiums or similar charges on Indians served by an IHCP; Indian Health Services; an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U); or through a Referral under Contract Health Services.

k. Contractor shall pay for Emergency Services that are performed by Non-Participating Providers as specified in OAR 410-141-3840.

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

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

(2) Require all Providers to identify Provider-Preventable Conditions that are associated with claims for CCO Payment or with courses of treatment furnished to Members for which CCO Payment would otherwise be available; and

(3) Report all identified Provider-Preventable Conditions in a form, frequency, and provided to OHA as may be specified by OHA from time to time; and

(4) In accordance with 42 CFR § 447.26(b) not make payment to Providers for Health Care-Acquired Conditions or Other Provider-Preventable Conditions that meet the following criteria:

(a) Is identified in the State Plan;

(b) Has been found by the State, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by Evidence-Based guidelines;

(c) Has a negative consequence for the Member;

(d) Is auditable; and

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

m. Contractor shall comply with the requirements related to claims payment for behavioral health and physical health services provided on the same day or in the same facility specified in Section 10 of Enrolled Oregon Senate Bill 1529 (2022) as specified in OAR Chapter 410

6. [RESERVED]

7. [RESERVED]

8. All Payer All Claims Reporting Program

The terms and conditions of Section 8, Exhibit B, Part 8 in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

9. Cost Growth Target Program

The terms and conditions of Section 9, Exhibit B, Part 8 in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

10. Health Care Market Oversight Program

The terms and conditions of Section 10, Exhibit B, Part 8 in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

11. Administrative Performance Program: Valid Encounter Claims Data

The terms and conditions of Section 11, Exhibit B, Part 8 in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

12. Encounter Data Submission Processes

The terms and conditions of Section 12, Exhibit B, Part 8 in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

13. Additional Encounter Data Submission Requirements: Non-Pharmacy Encounter Data

The terms and conditions of Section 13, Exhibit B, Part 8 in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

14. Pharmacy Encounter Data

The terms and conditions of Section 14, Exhibit B, Part 8 in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

15. Administrative Performance Standard

The terms and conditions of Section 15, Exhibit B, Part 8 in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

16. Drug Rebate Program

The terms and conditions of Section 16, Exhibit B, Part 8 in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

17. Drug Rebate Dispute Resolution Process

The terms and conditions of Section 17, Exhibit B, Part 8 in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

18. [RESERVED]

19. Personal Injury Liens

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

b. Contractor shall develop and implement written policies and procedures (P&Ps) regarding Personal Injury Liens. The PIL P&Ps shall be reviewed and approved based on compliance with this Sec. 19 of the Contract and applicable statutes and rules for the Personal Injury Lien program. The PIL P&Ps must be provided as a document separate from the TPLR P&Ps described in Sec. 18 of Ex. B, Part 8. The PIL P&Ps must include, at a minimum, all of the following:

(1) Policies and procedures related to personal injury liens that comply with ORS 416.510 through 416.610 and OAR 461-195-0301 through 461-195-0350;

(2) Any thresholds for determining whether to obtain a lien assignment; and

(3) And any other requirements as may be identified by PIL.

c. OHA will annually post on the CCO Contract Forms Website a document that identifies the content requirements for Contractor's PIL P&Ps. By January 31 of each Contract Year, Contractor shall submit to OHA, via Administrative Notice, an Attestation stating that its PIL P&Ps meet the requirements specified in the document identifying the PIL P&Ps content requirements. Contractor shall provide to OHA, via Administrative Notice, the PIL P&Ps that are the basis of its Attestation within five (5) Business Days of request by OHA. Without limiting any other rights and remedies OHA may have under this Contract, OHA has the right, in accordance with Ex. B, Part 9, to impose one or more Sanctions if it determines that Contractor's Attestation is false.

d. Contractor shall include in its Member Handbook the same content from its PIL P&Ps regarding the obligation of Members to provide information to, and cooperate with, Contractor in order for Contractor to meet its obligations under this Sec. 18, Ex. B, Part 8. The content regarding such Member obligations shall, when included in the Member Handbook, conform to the accessibility requirements described in the Member Handbook evaluation guidance located on the CCO Contract Forms Website. Contractor shall provide its Members with the applicable PIL content, or an updated Member Handbook with the applicable PIL content included, as follows:

(1) To all Members within thirty (30) days after Contractor's submission of the PIL P&Ps Attestation specified in Para. c above;

(2) To Potential Members before and during Enrollment; and

(3) To all Members within thirty (30) days after Contractor's submission of any PIL P&Ps Attestation subsequent to the annual Attestation specified in Para. c above.

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

f. Contractor shall inform the PIL Unit of all third parties who are legally liable for all or part of the fees paid by Contractor for services provided to a Member. Contractor shall inform PIL within thirty (30) days of learning of such potential liability, including personal injury protection under a motor

vehicle insurance policy, and such information must be made in accordance with OAR 461-195-0301 through 461-195-0350.

(1) Contractor shall inform PIL of such potential liability using the PIL secure web portal located at the following URL: https://apps.oregon.gov/OPAR/PIL/.

(2) After completing its report, Contractor is encouraged to print and maintain a copy of such Report in its files.

g. In no event shall Contractor request or require a Member to execute a trust agreement or loan receipt, subrogation agreement, or other similar arrangement to guarantee reimbursement of Contractor. Contractor's only right to reimbursement is to obtain a lien assignment from the Personal Injury Liens Unit.

h. Contractor shall obtain a written lien assignment from OHA or its designee prior to any attempt to seek reimbursement from a Member's, or a Member's beneficiary's, proceeds arising from an injury or death for which a third-party is financially legally liable. Contractor shall, in accordance with ORS 416.540 through 416.560 and OAR 461-195-0301 through 461-195-0325, perfect the lien and provide notice to all parties that are subject to the lien. Contractor shall then provide PIL with Administrative Notice that a lien has been filed. Such Administrative Notice must occur within ten (10) days after the lien was perfected. Contractor has no authority to sell or otherwise transfer its rights in the assigned lien, except to OHA or its designee. Contractor may contract with a third party to act as an agent on behalf of Contractor; however, Contractor shall retain ownership of the lien.

i. When Contractor is aware of a Third Party that may be legally liable for medical expenses paid by Contractor for a Member, Contractor shall request a lien assignment from the PIL Unit within thirty (30) days of receiving notice by completing the online request located at the following URL: https://apps.oregon.gov/OPAR/PIL/. At a minimum, Contractor shall provide the following information, if known, when requesting a lien assignment:

(1) Contractor's name;

(2) Member's name and address;

(3) Date of injury to the Member;

(4) Insurance or Attorney information for either the Member or a liable third party;

(5) Liable third party name and address; and

(6) Under comments of the online form, indicate "Request Lien Assignment."

j. Within five (5) Business Days after the end of each calendar month, Contractor shall provide the PIL Unit with a Report of a list of all active PIL cases and a list of all PIL cases compromised, closed, or terminated in a format specified by the PIL Unit. Such monthly Report shall include the following information:

(1) Contractor's name;

(2) All active liens/PIL cases;

(3) All liens that were compromised, closed, or terminated in the subject month;

(4) For all cases, all of the following information:

(a) The Member's name and Medicaid ID number;

(b) The date of the Member's injury;

(c) The amount of Contractor's lien;

(5) For all compromised, closed, or terminated liens:

(a) The date of any settlement or judgment, if known;

(b) The gross amount of any settlement or judgment, if known;

(c) The amount received from any liable third-party; and

(6) Any other information that PIL may request.

k. Contractor shall create Lien Release and Lien Filing Templates which shall be used when its Members may be entitled to seek recovery from third-parties who are potentially legally liable for all or part of the services provided to a Member and paid for by Contractor. The Lien Release and Lien Filing Templates must conform with the requirements of ORS 416.560, and, notwithstanding the authority to resolve a lien, Contractor has no other the authority to act on behalf of the State beyond the assigned lien.

l. OHA will provide Contractor with a document that identifies the content requirements for its Lien Release and Lien Filing Templates ("**Lien Templates**") for the then-current Contract Year. The document identifying the Lien Templates content requirements will be located on the CCO Contract Forms Website. By January 31 of each Contract Year, Contractor shall submit to OHA, via Administrative Notice, an Attestation stating that its Lien Templates meet the requirements specified in the document identifying the Lien Templates content requirements. Contractor shall provide to OHA, via Administrative Notice, the Lien Templates that are the basis of its Attestation within five (5) Business Days of request by OHA. Consistent with Ex. B, Part 9, OHA has the right to impose one or more Sanctions if it determines that Contractor's Attestation is false.

m. Contractor does not have the right to refuse to provide Covered Services and must not permit any of its Participating Providers to refuse to provide Covered Services to a Member because of potential Third Party Liability for payment for the Covered Service.

n. Contractor shall obtain the prior written approval of the PIL Unit before compromising any assigned lien. The PIL Unit will coordinate with Contractor or the plaintiff's attorney or both in compromising the PIL Unit's lien or Contractor's lien or both. In the event both Contractor and OHA have a lien against the same third-party, the lien filed by the PIL Unit is payable before Contractor's lien. Contractor or its Subcontractor shall respond to the PIL Unit's correspondence within five (5) Business Days of receipt.

o. If the PIL Unit has a lien that has not been paid in full, and Contractor has received payment on such lien, OHA shall have the right to off-set from Payments owing to Contractor the lesser of (i) the unpaid amount of the PIL lien, or (ii) the amount that Contractor received in satisfaction of such lien. The PIL Unit shall have the right to request, and Contractor shall promptly provide after the PIL Unit has so requested, access to Contractor's closed or resolved case files to determine if the PIL liens were paid in full.

p. If a Member fails to cooperate with Contractor as required under OAR 461-195-0303, Contractor shall notify OHA, via Administrative Notice, within ten (10) days of learning of such Member's failure to cooperate.

q. In the event a Member or a third-party initiates litigation to reduce or eliminate Contractor's assigned lien, or in the event Contractor determines litigation is required to defend or pursue Contractor's assigned lien, Contractor shall reassign the assigned lien to OHA as follows:

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

(2) Contractor shall cooperate with the PIL Unit and any designated Assistant Attorney General by providing all documentation and information requested by the PIL Unit, making witnesses available, and providing any other assistance that may be required to resolve any lien.

(3) Contractor's designated officer(s) shall execute the assignment of lien form provided by the PIL Unit and located on the CCO Contract Forms Website.

(4) Contractor shall permit the PIL Unit or Assistant Attorney General to communicate and work directly with any Subcontractor to efficiently undertake and manage any personal injury lien activity.

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

r. Contractor is the payer of last resort when there is other insurance (e.g., automobile insurance, workers' compensation, or similar coverage) in effect.

s. Contractor shall comply with 42 USC § 1395y(b) and 42 CFR Part 411, Subparts C-E, which gives Medicare the right to recover its benefits from employers and workers' compensation carriers, liability insurers, automobile or no fault insurers, and employer group health plans before any other entity including Contractor or its Subcontractors.

t. [RESERVED]

u. [RESERVED]

v. [RESERVED]

w. [RESERVED]

x. When engaging in Personal Injury recovery actions, Contractor shall comply with, and require Agents to comply with, the federal confidentiality requirements described in Sec. 6, Ex. E of this Contract and any other additional confidentiality obligations required under this Contract and State law. Contractor agrees to comply with ORS 416.510 through 416.610 when enforcing an assigned lien. OHA considers the disclosure of Member claims information made in connection with Contractor's Personal Injury recovery actions a purpose that is directly connected with the administration of the Medicaid program.

y. Contractor shall report to OHA all amounts recovered from the assignment of a Personal Injury Lien. Reporting shall be included on the Exhibit L Financial Reporting Template.

z. Contractor shall take all reasonable actions to pursue recovery of Personal Injury Liens for Covered Services provided to a Member. Generally, tort actions must be commenced within 2 years of the tort. The PIL Unit may, eighteen (18) months after the date of a potential tort injuring a Member, revoke a lien assignment and pursue the lien. Contractor will execute any documents needed to revoke or assign the lien to the PIL Unit. Contractor will cooperate with the PIL Unit and provide any information the PIL Unit needs to pursue the lien, including cooperation with any litigation.

aa. The PIL Unit will provide Contractor with all personal injury information available to the PIL Unit to assist in the pursuit of financial recovery as it pertains to Personal Injury Liens.

20. Disclosure of Ownership Interests

The terms and conditions of Section 20, Exhibit B, Part 8 in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

21. Disclosure of Other Ownership Interests

The terms and conditions of Section 21, Exhibit B, Part 8 in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

22. Certain Changes in Control Requiring Pre-Approval from OHA

The terms and conditions of Section 22, Exhibit B, Part 8 in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

23. Subrogation

The terms and conditions of Section 23, Exhibit B, Part 8 in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

24. Contractor's Governing Board

The terms and conditions of Section 24, Exhibit B, Part 8 in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

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Exhibit B – Statement of Work – Part 9 – Program Integrity

The terms and conditions of Exhibit B, Part 9 in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein

[Remainder of page intentionally left blank]

[Exhibit B – Statement of Work – Part 10 – Transformation Reporting, Performance Measures and External Quality Review is reserved.]

[Transformation Reporting, Performance Measures and External Quality Review are not required to be implemented under this Contract. Contractor's obligations to implement Transformation Reporting, Performance Measures and External Quality Review are only required under the Medicaid Contract.]

[Remainder of page intentionally left blank]

Exhibit C – Consideration

1. Payment Types and Rates

a. In consideration of all the Work to be performed under this Contract, OHA will pay Contractor a monthly CCO Payment for each Member enrolled under the Contract according to OHA records. The monthly CCO Payment Rate authorized for each Member is that amount indicated in Exhibit C-Attachment 1 (CCO Payment Rates) for each Member's Rate Group. OHA may withhold Payment for new Members when, and for so long as, OHA Imposes suspension or denial of Payments as a Sanction under Ex. B, Part 9, Sec. 3, Para. b.

b. The monthly CCO Payment may include risk adjustment based factors such as expected cost of care or health status and may reflect one or more Risk Corridors in accordance with Sec. 6 below of this Ex. C.

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

d. Contractor's separate Medicaid Contract includes provisions relating to Qualified Directed Payments (**QDPs**), which are State-directed payments governed by CMS Medicaid managed care regulations. The CMS managed care regulations relating to QDPs permit States to include terms and conditions in their managed care contracts that require managed care organizations (**MCOs**), such as Contractor and other CCOs, to pay certain providers for specific services, programs, initiatives, and other matters. The CCO Payment Rates that Contractor is paid under its Medicaid Contract have the sums attributable to the QDPs (which are based on actuarially sound calculations) payable under the Medicaid Contract built into the CCO Payment Rates (**"QDPs within CCO Payment Rates"**). In accordance with 42 CFR §438.6(c), QDPs within CCO Payment Rates are subject to prior written approval from CMS. The states' Medicaid agencies, including OHA, obtains approval from CMS by submitting a request using a templated form called a "Preprint." Contractor's separate Medicaid Contract also includes QDPs that must align with State Plan payment rates, but those QDPs are not subject to approval from CMS.

Under this OHP Bridge -BHP Contract, Contractor is required to make directed payments related to certain QDPs in the Medicaid Contract. These directed payments are reflected in the CCO Payment Rates set forth in the attached Exhibit C-Attachment 1 to this OHP Bridge -BHP Contract and are described in Sub-Sub.Paras. (a) – (f) of Sub.Para. (1) below of this Para. d. All of the foregoing QDPs are also included in and required to be paid out under Contractor's separate Medicaid Contract and the amounts payable thereunder shall be based on the services provided under and data related to the Medicaid Contract only.

OHA will provide a QDP Guidance Document to assist Contractor in complying with the QDPs in Sub-Sub.Paras. (a) – (f) of Sub.Para. (1) below and the flexibility relating to Alternative Payment Methodologies in Sub.Para. (2) below.

(1) The QDPs required to be paid out under this Non-Medicaid Contract are as follows:

(a) "***Increased Payments for Assertive Community Treatment (ACT), Supported Employment Services (SE), Outpatient Mental Health Treatment and Services (OP MH), and Outpatient Substance Use Disorder Treatment and Services (OP SUD) for Primarily Medicaid Providers.***" The terms and conditions applicable to the foregoing QDP are set forth in Ex. C, Sec. 1, Para. d, Sub.Para. (2), Sub-

Sub.Para. (a) of the Medicaid Contract and are incorporated by reference in this Sub-Sub.Para. (a) as though fully set forth herein.

(b) "***Culturally and Linguistically Specific Services (CLSS) Payment Increase for BH Participating Providers.***" The terms and conditions applicable to the foregoing QDP are set forth in Ex. C, Sec. 1, Para. d, Sub.Para. (2), Sub-Sub.Para. (b) of the Medicaid Contract and are incorporated by reference in this Sub-Sub.Para. (b) and as though fully set forth herein.

(c) "***Culturally and Linguistically Specific Services (CLSS) Payment Increase for Traditional Health Workers (THWs).***" The terms and conditions applicable to the foregoing QDP are set forth in Ex. C, Sec. 1, Para. d, Sub.Para. (2), Sub-Sub.Para. (c) of the Medicaid Contract and are incorporated by reference in this Sub-Sub.Para. (c) as though fully set forth herein.

(d) "***Co-Occurring Disorder (COD) Services Payment Increase.***" The terms and conditions applicable to the foregoing QDP are set forth in Ex. C, Sec. 1, Para. d, Sub.Para. (2), Sub-Sub.Para. (d) of the Medicaid Contract and are incorporated by reference in this Sub-Sub.Para. (d) as though fully set forth herein.

(e) "***Dental Services Add-on Payment.***" The terms and conditions applicable to the foregoing QDP are set forth in Ex. C, Sec. 1, Para. d, Sub.Para. (2), Sub-Sub.Para. (e) of the Medicaid Contract and are incorporated by reference in this Sub-Sub.Para. (e) as though fully set forth herein.

(f) "***Minimum Fee Schedule for Providers of Residential SUD, ABA, Mobile Crisis Services, Mobile Crisis Intervention Services, and Wraparound.***" The terms and conditions applicable to the foregoing QDP are set forth in Ex. C, Sec. 1, Para. d, Sub.Para. (2), Sub-Sub.Para. (h) of the Medicaid Contract and are incorporated by reference in this Sub-Sub.Para. (f) as though fully set forth herein.

(2) "***Alternative Payment Methodologies (APMs).***" The terms and conditions applicable to the foregoing flexibility relating to QDPs is set forth in Ex. C, Sec. 1, Para. d, Sub.Para. (2), Sub-Sub.Para. (i) of the Medicaid Contract and are incorporated by reference in this Sub.Para. (2) as though fully set forth herein.

(3) For the purpose of awareness only, Contractor's Medicaid Contract includes two QDPs that will utilize data relating to services provided to all (i) Members covered by this OHP Bridge -BHP Contract , (ii) Medicaid Members covered under Contractor's separate Medicaid Contract; and (iii) The HOP, COFA, Dental Program, and Veteran Dental Members covered under Contractor's separate Non-Medicaid Contract. Those QDPs are called the "***New Dental Provider Incentive***" and "***Existing Dental Provider Access Incentive,***" the terms and conditions of which are set forth in Ex. C, Sec. 1, Para. d, Sub.Para. (2), Sub-Sub.Paras. (f) and (g), respectively, of the Medicaid Contract. However, Contractor is not required to make any payments for the foregoing QDPs under this OHP Bridge -BHP Contract.

(4) All payments payable under this OHP Bridge -BHP Contract shall be made after OHA receives CMS approval for the QDPs included in the Medicaid Contract. OHA shall notify Contractor of such approval via Administrative Notice.

e. As described in OAR 410-141-3565, OHA may require Contractor to reimburse a Rural Type A Hospital or Rural Type B Hospital for the cost of Covered Services based on a Cost-to-Charge Ratio. This section does not prohibit Contractor and such a Hospital from mutually agreeing to reimbursement arrangements.

f. If Contractor has a contractual relationship with a designated Type A, Type B, or Rural critical access Hospital, Contractor shall provide representations and warranties to OHA that said contract establishes the total reimbursement for the services provided to persons whose medical assistance benefits are administered by Contractor.

2. Payment in Full

The consideration described in this Ex. C is the total consideration payable to Contractor for all Work performed under this Contract. OHA will ensure that no Payment is made to a Provider other than Contractor for services available under the Contract between OHA and Contractor.

3. Changes in Payment Rates

a. The CCO Payment Rates may be changed only by amendment to this Contract pursuant to Sec. 21, Ex. D.

b. In the event CCO Payment Rate adjustments are required, and such Payment Rates are decreased as a result thereof, OHA shall have the right to recover the difference between amounts paid in excess of the decreased amount; however, OHA shall ensure such amounts are recovered in a manner that does not have a material, adverse effect on Contractor's ability to maintain the required minimum amounts of risk-based capital as such minimum amount is set forth in Ex. L of this Contract.

c. Changes in the CCO Payment Rates as a result of adjustments to the Service Area or to the Enrollment limit may be required pursuant to Sec. 13, Ex. B, Part 4 of this Contract.

d. The CCO Payments authorized to be paid under this Contract are based on the funded condition-treatment pairs on the Prioritized List of Health Services in effect on the Effective Date of this Contract, subject to the terms of this Contract. Changes in the Prioritized List are addressed as follows:

(1) Pursuant to ORS 414.690, the Prioritized List developed by the Health Evidence Review Commission may be expanded, limited or otherwise changed. Pursuant to ORS 414.690 and 414.735, the funding line for the services on the Prioritized List may be changed by the Legislature.

(2) In the event that insufficient resources are available during the Term of this Contract, ORS 414.735 provides that reimbursement shall be adjusted by eliminating services in the order of priority recommended by the Health Evidence Review Commission, starting with the least important and progressing toward the most important.

(3) Before instituting reductions in Covered Services pursuant to ORS 414.735, OHA will obtain the approval of the Legislative Assembly or the Emergency Board if the Legislative Assembly is not in session.

(4) If legislative scheduling permits, OHA will provide Contractor Administrative Notice to Contractor's Contract Administrator at least two (2) weeks prior to any legislative consideration of such reductions in Covered Services pursuant to ORS 414.735(3).

(5) Notwithstanding the foregoing, Para. d, Sub.Paras. (1) through (4) of this Sec. 3, Ex. C do not apply to reductions made by the Legislative Assembly in a legislatively adopted or approved budget.

e. [RESERVED]

f. This Sec. 3 applies to any change to the CCO Payment Rates made by a Contract amendment that has retroactive effect or that cannot be implemented before the next regularly scheduled date for Payment. If such change increases the CCO Payment owed by OHA to Contractor, then OHA will make a Payment to Contractor, by one-time adjustment to a future regularly scheduled Capitation Payment or by separate Payment. If such change decreases the CCO Payment owed by OHA to Contractor, then any amount paid to Contractor in excess of the decreased amount will be subject to recovery under Para b above of this Sec. 3, Ex. C and Sec. 7, Ex. D and any other applicable provisions of this Contract governing Overpayments.

4. Timing of CCO Payments

a. The date on which OHA will process CCO Payments for Contractor's Members depends on whether the Enrollment occurred during a weekly or monthly Enrollment cycle. OHA will provide a schedule of Enrollment end of month deadlines for each month of the Contract period. On months where the first of the month falls on a Friday, Saturday or Sunday, CCO Payments will be made available to Contractor no later than the eleventh (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 will be made available to Contractor by the tenth (10th) day of the month to which such Payments are applicable, except for those occurrences each year when the weekly and monthly CCO Payments coincide with each other.

b. Both sets of Payments described in Para. a. of this Sec. 4 will appear in the weekly/monthly 820 Group Premium Payment (Capitation) Transaction and in the weekly 835 Payment/Remittance Advice Transaction. To assist Contractor with Enrollment and CCO Payment/Remittance Advice reconciliation, OHA will include in the weekly/monthly 820 Group Premium Payment (Capitation) Transaction the original adjustment amount and the paid amount for each of Contractor's Members. The inclusion of this information does not ensure that the two transaction files will balance. If Contractor believes that there are any errors in the Enrollment information, Contractor shall provide OHA's Contract Administrator with Administrative Notice of such errors. Contractor may request an adjustment to the Remittance Advice no later than eighteen (18) months from the affected Enrollment period.

c. OHA will make retroactive CCO Payments to Contractor for any Member(s) erroneously omitted from the Enrollment transaction files. Such payments will be made to Contractor once OHA processes the correction(s).

d. [RESERVED]

e. [RESERVED]

5. Settlement of Accounts

a. If a Member is Disenrolled, any CCO Payments received by Contractor for the period for which the Member was Disenrolled will be considered an Overpayment and will be recouped by OHA under Para. f. below of this Sec. 5, Ex. C.

b. OHA will have no obligation to make any Payments to Contractor for any period(s) during which Contractor is in breach of this Contract, to the extent that Sanctions imposed under this Contract include suspending or withholding Payments.

c. If Contractor requests, or is required by OHA, to adjust the Service Area or Enrollment limit or to transfer or reassign Members due to loss of Provider capacity or for other reasons, the Parties will execute an amendment modifying the applicable provisions of the Contract. If Payments made starting on the effective date of the reduction of the Service Area or Enrollment limit exceed the amount of Payments to which Contractor was entitled under the amendment, OHA will have the right to recover any such Overpayments.

d. Any Payments received by Contractor from OHA under this Contract, and any other payments received by Contractor from OHA pursuant to any other contract or agreement between Contractor and OHA, or pursuant to any other circumstances that result in a claim by OHA for the recovery of amounts previously paid to Contractor by OHA, or Contractor received funds from any other source, to which Contractor is not entitled under the terms of this Contract, such payments or funds received shall be deemed an Overpayment and OHA will have the right to recover such Overpayment from Contractor in accordance with Sec. 7, Ex. D of this Contract. OHA shall ensure that recovery of Overpayments do not have a material, adverse effect on Contractor's ability to maintain its required, minimum amount of risk-based capital.

e. OHA has the right to recover Sanctions imposed in the form of civil money penalties imposed under Ex. B, Part 9 of this Contract by Recouping such amounts in accordance with Ex. B, Part 9 or Sec. 7 of Ex. D to this Contract.

f. Any Overpayment or recovery amount imposed under Ex. B, Part 9 or Ex. C of this Contract may be recovered by Recoupment from any future payments to which Contractor would otherwise be entitled from OHA (e.g., setoff from amounts that may be owing to Contractor), without limitation or waiver of any legal rights. OHA will have the right to withhold payments to Contractor for amounts in dispute and shall not be charged interest on any payments so withheld.

g. OHA will Recoup from Contractor Payments made to Contractor or amounts paid to Providers for sterilizations and hysterectomies performed where Contractor failed to meet the requirements of Ex. B, Part 2, Sec. 6, Para. c. of this Contract. The Recoupment amount will be calculated as follows:

(1) Contractor shall, within sixty (60) days of a request from OHA, provide OHA with a list of all Members who received sterilizations or hysterectomies, from Contractor or its Subcontractors during the Contract period and copies of the informed consent forms or certifications. OHA will have the right to review the Medical Records of these individuals selected by OHA for purposes of determining whether Contractor complied with OAR 410-130-0580.

(2) By review of the informed consent forms, certifications, and other relevant Medical Records of Members, OHA will determine for the Contract period at issue the number of sterilizations and hysterectomies provided or authorized by Contractor or its Subcontractors that did not meet the requirements of Ex. B, Part 2, Sec. 6, Para. c of this Contract.

(3) Sterilizations and hysterectomies that Contractor denied for payment shall not be included in the Recoupment calculation, however, they must be reported in the submission. The report of these sterilizations and hysterectomies must be accompanied by a signed statement certifying that Contractor did not make payment for the surgery or any services, which are specifically related to the procedure.

(4) The number of vasectomy, tubal ligation, and hysterectomy procedures that do not meet the documentation requirements of Ex. B, Part 2, Sec. 6, Para. c of this Contract, shall be multiplied by the assigned "value of service."

(5) "Value of service" for vasectomy, tubal ligation, and hysterectomy means the OHP amount calculated by OHA's internal actuarial unit for each category of service using the Encounter Data.

(6) The results of Sub.Para (4) of this Para. g, Sec. 5, Ex. C will be totaled to determine the amount of Overpayment made to Contractor for hysterectomies and sterilizations subject to recovery pursuant to Sec. 7, Ex. D, this Contract.

(7) The final results of the review and recovery calculation will be provided to Contractor's Contract Administrator, via Administrative Notice, in a timely manner within ninety (90) days of OHA determination of amounts owed and recovery shall be made in accordance with Sec. 7, Ex. D of this Contract.

6. CCO Risk Corridors

Contractor shall comply with the requirements for administration of the Risk Corridors established in this Sec. 6. The CCO Risk Corridors utilize specific percentages above and below a target amount, establishing "bands" of risk, which define how Contractor and OHA will review the adjusted costs of the expenses of Members receiving eligible services, subject to settlement.

a. CCO Risk Corridor Definitions

(1) "BHP Risk Corridor Period" means July 1, 2024, through December 31, 2025.

(2) "BHP Expense" means priced encounters offset by reinsurance recoveries and drug rebates, along with other OHA-approved costs or adjustments reflected in Contractor's completed BHP Settlement Calculation Form, for Covered Services for BHP Members for dates of service during the BHP Risk Corridor Period. For purposes of calculating BHP Expense, Contractor may not claim payment to any Provider for a service provided to a BHP Member under this Contract in an amount greater than the same Provider would be paid by Contractor for the same service if provided to a Member under Contractor's Medicaid Contract.

(3) "BHP Revenue" means the amount paid to Contractor by OHA for BHP Members in Capitation Payments and case rate payments for dates of service during the BHP Risk Corridor Period, after the application of Section 11 below (including similar provisions as expected to apply for CY25), and excluding the administrative component of the rates and any managed care tax.

(4) "BHP Settlement Calculation Form" means the form provided to Contractor by OHA for calculating the BHP settlement covering the BHP Risk Corridor Period.

b. Operation of the CCO Risk Corridor for Covered Services rendered during the BHP Risk Corridor Period.

(1) BHP Settlements:

(a) No later than April 24, 2026, Contractor shall submit Encounter Data to OHA for Covered Services provided to BHP Members for dates of service during the BHP Risk Corridor Period. Contractor is responsible for ensuring that encounter claims data are received and successfully processed by OHA prior to the submission deadline.

(b) Following receipt of Encounter Data, OHA shall provide the BHP Settlement Calculation Form to Contractor.

(c) In preparing the BHP Settlement Calculation Form, OHA will reprice Encounter Data claims that have no paid amounts using methods OHA publishes when it provides the BHP Settlement Calculation Form to Contractor.

(d) OHA will use BHP Member enrollment data multiplied by the BHP capitation rates for each Category of Aid (COA) and BHP case rates to calculate the BHP Revenue.

(e) Contractor shall review and reply to the BHP Settlement Calculation Form provided by OHA within forty-five (45) days of receipt. Contractor's reply shall include OHA-requested cost information such as incurred but not reported costs, and other Member service expenses.

(f) OHA will review Contractor's response to the settlement calculation within forty-five (45) days of the due date for Contractor's response. The outcome of OHA's review will be to accept, modify, or request further information on Contractor's calculation of BHP Expense, and to indicate the amount of the BHP Risk Corridor Payment.

(g) If Contractor does not agree with OHA's settlement calculation, Contractor may, by notice delivered by email to OHA's Contract Administrator within ten (10) Business Days of OHA's delivery to Contractor of OHA's settlement calculation, seek Administrative Review of Contractor's settlement calculation.

(2) BHP Risk Corridor Payments

(a) The outcome of the settlement calculation process will be used to determine whether OHA owes a payment to Contractor or Contractor owes a payment to OHA. The following payments will be made after the BHP Revenue and BHP Expenses have been determined for the BHP Risk Corridor Period.

(b) Contractor will receive a payment from OHA in the following amounts under the following circumstances:

(i) When Contractor's BHP Expenses for the BHP Risk Corridor Period are between one hundred three percent (103%) and one hundred ten percent (110%) of the BHP Revenue, OHA will pay Contractor an amount equal to fifty percent (50%) of the BHP Expenses between one hundred three percent (103%) and one hundred ten percent (110%) of the BHP Revenue; or

(ii) When Contractor's BHP Expenses for the BHP Risk Corridor Period are equal to or greater than one-hundred ten percent (110%) of the BHP Revenue, OHA will pay Contractor an amount equal to one hundred percent (100%) of BHP Expenses in excess of one hundred ten percent (110%) of the BHP Revenue, and fifty percent (50%) of BHP Expenses between one hundred three percent (103%) and one hundred ten percent (110%) of BHP Revenue.

(c) Contractor will owe a payment to OHA in the following amounts under the following circumstances:

(i) When Contractor's BHP Expenses for the BHP Risk Corridor Period are between ninety percent (90%) and ninety-seven percent (97%) of the BHP Revenue, Contractor shall owe OHA an amount equal to fifty percent (50%) of the excess between ninety-seven percent (97%) of the BHP Revenue and the BHP Expenses; or

(ii) When Contractor's BHP Expenses for the BHP Risk Corridor Period are less than or equal to ninety percent (90%) of the BHP Revenue, the Contractor shall owe OHA an amount equal to one hundred percent (100%) of the difference between the Contractor's BHP Expenses and ninety percent (90%) of the BHP Revenue; and the Contractor shall owe OHA fifty percent (50%) of BHP Revenue between ninety percent (90%) and ninety-seven percent (97%) of BHP Revenue.

(iii) If Contractor owes a payment to OHA, then OHA will confer with Contractor about the method and timing of the payment or charge, which may include adjusting future payments to Contractor.

7. Global Payment Rate Methodology

a. 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 "OHP Bridge - Basic Health Program (BHP) 2024 Actuarial Certification." Actuarial Reports are available at https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/OHP-Rates.aspx. Actuarial Reports are not part of this Contract, and except where specifically referred to herein, may not be used in the interpretation or construction of this Contract.

b. Capitation Rates paid to Contractor may include a component of Performance Based Reward (PBR) program similar to provisions incorporated in the State 1115 Waiver. The waiver specifies that OHA will fund Health-Related Services (HRS) through the Oregon Health Plan and establish financial incentives for successful HRS spending. The purpose of the PBR program is to incentivize Coordinated Care Organizations (CCOs) to pay for HRS that will improve health and reduce medical cost. The PBR program pays a variable underwriting margin to CCOs based on their HRS investments and success in controlling overall cost growth as well as an assessment of Quality Measures. The PBR formula contains limits to ensure that the impact on Capitation Rates remains within actuarially sound limits. Contractor's participation in the PBR program is voluntary, and the conditions of that participation will be communicated by OHA, via Administrative Notice, to Contractor in connection with Capitation Rates development. The amount of overall PBR funds available, specific formula parameters, and the resulting calculations are provided in the Actuarial Report referenced in Paragraph a. above of this Section 7.

8. Administrative Performance Penalty

With implementation of the Administrative Performance (AP) Standard, OHA utilizes an AP Penalty methodology in accordance with Ex. B, Part 8, Sec. 15.

9. [RESERVED]

10. Minimum Medical Loss Ratio

In accordance with 42 CFR § 600.415 if Contractor is deemed by CMS to be health insurance coverage offered by a health insurance issuer, the Contractor shall maintain a Minimum Medical Loss Ratio (MMLR) at or above the MMLR Standard. At the time of contract issuance, OHA understands that this provision does not apply, and therefore in consideration of the impact of the risk corridor under Section 6, waives for the contract period the MMLR Standard and any related reporting requirements. In the event that CMS determines an MMLR Standard must be met, or the risk corridor under Section 6 ceases to apply, Contractor shall submit an annual, certified MMLR Rebate Report which validates its compliance with this requirement, using a template similar to that used under the Contractor's Medicaid contract, and abiding by provisions similar to the Medicaid contract but for differences necessitated by the different legal structure of the BHP. In the event that MMLR reporting becomes required, OHA shall publish a reporting template, required provisions, and related guidance for Contractor.

11. Retroactive Rate Adjustment

The purpose of this Section 11 is to provide the background, process, and methodology for OHA's retroactive adjustment of Contractor's CCO Payment Rates for July 1, 2024, through December 31, 2024, (the "Review Period") and of CCO Payments paid to Contractor for the Review Period.

a. Background

The actuarially set CCO Payment Rates for Members occurred before sufficient data were available to calculate capitation rates that reflect the risk of the Members actually covered during the Review Period. OHA will initially pay Contractor at the CCO Payment Rates set forth in Exhibit C-Attachment 1, "CCO Payment Rates". OHA will then undertake a retrospective rate analysis for the Review Period, the result of which will be actuarially sound CCO Payment Rates for each CCO for each Contract Year, retroactive for the entire Review Period (the "Risk-Adjusted CCO Payment Rates"). The adjustments to CCO Payment Rates through this process will be based on Member risk factors for the actual membership with the CCOs.

b. Process and Methodology

The methodology for and the requirements of the analysis and retroactive Payment Rate adjustments for the Review Period are as follows:

(1) Data: For the retroactive rate adjustments, OHA will evaluate the Enrollment and Encounter data for each CCO, extracted from OHA's systems after March 31, 2025.

(2) Budget Neutrality: CCO Payment Rates will be retroactively risk-adjusted in a budget-neutral manner, starting from statewide base data, to reflect each CCO's membership and its impact on risk scores across and within rate setting regions.

(3) Risk Score Methodology: Unless otherwise documented and substantiated to CCOs, OHA will utilize the CDPS+Rx model with concurrent weights for risk adjustments to the CCO Payment Rates.

(4) Preliminary Results: OHA will provide Contractor, via Administrative Notice, with its preliminary Risk-Adjusted CCO Payment Rates for the Review Period at least 14 calendar

days prior to OHA's issuance of Contractor's final Risk-Adjusted CCO Payment Rates. OHA will provide Contractor with an opportunity to review and provide feedback on its preliminary Risk-Adjusted CCO Payment Rates.

(5) Amendment with Final Risk-Adjusted Rates: OHA will provide the final CCO-specific Risk-Adjusted Payment Rates to Contractor by Administrative Notice no later than November 30, 2025, in the form of a mandatory amendment to the Contract, replacing the previously applicable CCO Payment Rates with the final Risk-Adjusted CCO Payment Rates. Contractor shall sign and return the mandatory amendments described in this paragraph within fourteen (14) days of the Administrative Notice providing the amendment to Contractor. Contractor waives the 60-day advance notice period of ORS 414.590(5) for these amendments. Failure of Contractor to sign and return the mandatory amendment will be grounds for OHA to terminate this Contract, without prejudice to OHA's right to recoupment as described in the following paragraph.

(6) Recoupment or Additional Payment: OHA will recoup from or pay to Contractor all Payments for the Review Period resulting from the CCO Payment Rates prior to adjustment. OHA will consult with Contractor in development of any recoupment schedule.

Appeal: If Contractor disagrees with the net amount of the recoupment or payment resulting from the CCO-specific Payment Rates described in Paragraph a. of this Section 9, Contractor may file an appeal via Administrative Notice to OHA's Contract Administrator within ten (10) Business Days of OHA's delivery of the final CCO-specific Payment Rates. Any appeal shall be conducted as an Administrative Review and 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 final CCO-specific Payment Rates. The Administrative Review decision will result in the final CCO-specific Payment Rates if an appeal was timely filed.

[Remainder of page intentionally left blank]

Exhibit D – Standard Terms and Conditions

1. Governing Law, Consent to Jurisdiction

The terms and conditions of Section 1, Exhibit D in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

2. Compliance with Applicable Law

a. *The terms and conditions of Paragraph a of Section 2, Exhibit D in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.*

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 Potential Members, 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 all 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

The terms and conditions of Section 3, Exhibit D in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

4. Representations and Warranties

The terms and conditions of Section 4, Exhibit D in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

5. Correction of Deficient Documents

The terms and conditions of Section 5, Exhibit D in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

6. Funds Available and Authorized; Payments

The terms and conditions of Section 6, Exhibit D in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

7. Recovery of Overpayments or Other Amounts Owed by Contractor

a. **IF PAYMENTS UNDER THIS CONTRACT, OR UNDER ANY OTHER CONTRACT BETWEEN CONTRACTOR AND OHA, INCLUDING THE MEDICAID CONTRACT, RESULT IN PAYMENTS TO CONTRACTOR TO WHICH CONTRACTOR IS NOT ENTITLED (I.E., OVERPAYMENT) OR IN THE EVENT CONTRACTOR FAILS TO TIMELY PAY SUMS OWING TO OHA (E.G., CIVIL MONETARY PENALTIES), OHA SHALL HAVE THE RIGHT TO PURSUE A RECOVERY, FOLLOWING THE ADMINISTRATIVE PROCEDURES SET FORTH BELOW IN PARAGRAPH b OF THIS SEC. 7. FOLLOWING EXHAUSTION OF THE ADMINISTRATIVE PROCEDURES SET FORTH BELOW IN PARAGRAPH b OF THIS SEC. 7, CONTRACTOR HEREBY REASSIGNS TO OHA ANY RIGHT CONTRACTOR MAY HAVE TO RECEIVE SUCH PAYMENTS. OHA RESERVES ITS RIGHT TO PURSUE ANY OR ALL OF THE REMEDIES AVAILABLE TO IT UNDER THIS CONTRACT AND AT LAW OR IN EQUITY INCLUDING OHA'S RIGHT TO SETOFF UNDER THIS CONTRACT, THE MEDICAID**

CONTRACT, ANY OTHER CONTRACT ENTERED INTO BY AND BETWEEN OHA AND CONTRACTOR, OR ANY OTHER CIVIL REMEDY.

b. *The terms and conditions of Paragraph b of Section 7, Exhibit D in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.*

8. Indemnity

The terms and conditions of Section 8, Exhibit D in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

9. Default; Remedies; and Termination

a. Default by Contractor. Contractor shall be in default under this Contract if:

(1) Contractor institutes or has instituted against it insolvency, receivership or bankruptcy proceedings, makes an assignment for the benefit of creditors, or ceases doing business on a regular basis; or

(2) Contractor no longer holds a license or certificate that is required for Contractor to perform its obligations under this Contract and Contractor has not obtained such license or certificate within fourteen (14) days after receipt of OHA's Legal Notice or such longer period as OHA may specify in such Legal Notice; or

(3) Contractor's fails to ensure that no cancellation, material change, potential exhaustion of aggregate limits or non-renewal of insurance coverage(s) occurs without sixty (60) days prior written notice from Contractor or its insurer(s), which shall be made to OHA via Administrative Notice to OHA's Contract Administrator; or

(4) Contractor commits any breach of any covenant, warranty, obligation or agreement under this Contract, fails to perform the Work under this Contract within the time specified herein or any extension thereof, or so fails to pursue the Work as to endanger Contractor's performance under this Contract in accordance with its terms, and such breach or failure is not cured within fourteen (14) days after receipt of OHA's Notice, or such longer period as OHA may specify in such Notice; or

(5) Contractor knowingly has a relationship with a Person described in Sub.Para. (6) below, concerning whom:

(a) Any license or certificate required by law or regulation to be held by Contractor or Subcontractor to provide services required by this Contract is for any reason denied, revoked, or not renewed; or

(b) Is suspended, debarred, or otherwise excluded from participating in procurement activities under Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued pursuant to Executive Order No. 12549 or under guidelines implementing such order; or

(c) Is suspended or terminated from the Medical Assistance Program or excluded from participation in the Medicare program; or

(d) Is convicted of a felony or misdemeanor related to a crime or violation of Title XVIII, XIX, or XX of the Social Security Act or related laws (or entered a plea of nolo contendere).

(6) The prohibited affiliations in Sub.Para. (5) above apply to a Person that:

(a) Is a director, officer, or partner of Contractor;

(b) Is a subcontractor of Contractor;

(c) Has beneficial ownership of 5 percent or more of Contractor's equity; or

(d) Is a network provider or person with an employment, consulting, or other arrangement with Contractor for the provision of items and services that are significant and material to Contractor's obligations under this Contract.

(7) If OHA determines that health or welfare of Members is in jeopardy if this Contract continues;

(8) Contractor fails to enter into an amendment described in Sec. 21, Para. b below of this Ex. D, as necessary for the amendment to go into effect on its proposed effective date; or

(9) Contractor is in breach of any other contract entered into with the State pursuant to which Contractor provides the same or substantively similar services as those provided under this Contract (e.g., the Non-Medicaid Contract or the Medicaid Contract, or another CCO contract entered into with OHA pursuant to which Contractor administers a Medical Assistance Program in a different Service Area than this Contract).

(10) Any notice of default by Contractor shall identify, with specificity, the term or terms of this Contract allegedly breached.

b. OHA's Remedies for Contractor's Default. In the event Contractor is in default under Sec. 9, Para. a, above of this Ex. D, OHA may, at its option, pursue any or all of the remedies available to it under this Contract and at law or in equity, including, but not limited to:

(1) Termination of this Contract under Sec. 9, Para. e, Sub. Para. (2) below of this Ex. D. below;

(2) Withholding all monies due for Work and Work Products that Contractor has failed to deliver within any scheduled completion dates or has performed inadequately or defectively;

(3) Sanctions, including civil monetary penalties if applicable, as permitted under Ex. B, Part 9 of this Contract;

(4) Initiation of an action or proceeding for damages, specific performance, declaratory or injunctive relief; and

(5) Recoupment or Withholding of Overpayments under Sec. 7 above of this Ex. D or Offset or both.

These remedies are cumulative to the extent the remedies are not inconsistent, and OHA may pursue any remedy or remedies singly, collectively, successively or in any order whatsoever.

c. Default by OHA. *The terms and conditions of Paragraph c of Section 9, Exhibit D in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.*

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d. Contractor's Remedies for OHA's Default. *The terms and conditions of Paragraph d of Section 9, Exhibit D in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein*.

e. Termination

(1) OHA's Right to Terminate at its Discretion. At its sole discretion and without liability to Contractor, OHA may terminate this Contract:

(a) Without cause upon ninety (90) days' prior written Legal Notice of termination by OHA to Contractor; or

(b) Upon receipt of written Legal Notice of termination or the effective date otherwise identified in such Legal Notice if OHA fails to receive funding, appropriations, limitations, allotments or other expenditure authority at levels sufficient to allow OHA, in the exercise of its discretion, to continue to make payments under this Contract; or

(c) Upon receipt of written Legal Notice of termination or the effective date otherwise identified in such Legal Notice, if federal or State laws, regulations, or guidelines are modified or interpreted in such a way that OHA's purchase or continued use of the Work or Work Products under this Contract is prohibited or OHA is prohibited from paying for such Work or Work products from the planned funding source; or

(d) Notwithstanding any claim Contractor may have under Sec. 16, "Force Majeure," upon receipt of written Legal Notice of termination to Contractor if OHA determines that continuation of the Contract poses a threat to the health, safety, or welfare of any Member, or any other OHP or Medicaid eligible individual under Contractor's care.

(2) OHA's Right to Terminate for Cause. In addition to any other rights and remedies OHA may have under this Contract, and subject to Sec. 9, Para. e, Sub. Para. (4) below of this Ex. D, OHA will have the right, at its sole discretion and without liability to Contractor, to issue Legal Notice to Contractor that OHA is terminating this Contract upon the occurrence of any of the following events:

(a) Contractor is in default under Sec. 9, Para. a, Sub. Para. (1) above of this Ex. D because Contractor has instituted or has had instituted against it insolvency, receivership or bankruptcy proceedings, makes an assignment for the benefit of creditors, or ceases doing business on a regular basis; or

(b) Contractor is in default under Sec. 9, Para. a, Sub. Para. (2) above of this Ex. D because Contractor no longer holds a license or certificate that is required for it to perform Work under the Contract and Contractor has not obtained such license or certificate; or

(c) Contractor is in default under Sec. 9, Para. a, Sub. Para. (4) above of this Ex. D because Contractor commits any breach of any covenant, warranty, obligation or agreement under this Contract, fails to perform the Work under this Contract within the time specified herein or any extension thereof, or so fails to pursue the Work as to endanger Contractor's performance under this Contract in accordance with its terms.

(d) Contractor has failed to carry out the substantive terms of its Contract or meet the applicable requirements under the Patient Protection and Affordable Care Act.

(3) OHA's Right to Terminate due to Termination or Non-Renewal of a Similar Contract.

(a) In the event OHA terminates a different contract that Contractor has entered into with the State pursuant to which Contractor provides the same or substantively similar services as those provided under this Contract (e.g., the Medicaid Contract, the Non-Medicaid Contract, or another CCO contract entered into with OHA pursuant to which Contractor administers a Medical Assistance Program in a different Service Area than this Contract), OHA shall have the right, but not the obligation, in its sole discretion, to terminate this Contract.

(b) In the event Contractor declines to Renew a different contract that Contractor has entered into with the State pursuant to which Contractor provides the same or substantively similar services as those provided under this Contract (e.g., the Medicaid Contract or the Non-Medicaid Contract) which covers the same Service Area as this Contract, OHA shall have the right, but not the obligation, in its sole discretion, to terminate this Contract. For the purpose of clarification, OHA will not have the right to terminate this Contract in the event Contractor declines to Renew another CCO contract entered into with OHA pursuant to which Contractor administers a Medical Assistance Program in a different Service Area than this Contract.

(4) Before Terminating this Contract under this Sec. 9, Para. e, Sub. Para (1) or Sub. Para. (2) above of this Ex. D, OHA will:

(a) Provide Contractor an opportunity to request Administrative Review of the Legal Notice of termination or Legal Notice of OHA's intent to terminate pursuant to OAR 410-120-1560 and 410-120-1580. If no Administrative Review is requested or following the Administrative Review and any appeals thereof the Contract shall be terminated in accordance with the Legal Notice of termination. Where termination is based on failure to comply with a Corrective Action and Contractor has already had an Administrative Review on issues substantially similar to the basis for the proposed termination, such Administrative Review, subject to any appeal thereof, is deemed to satisfy any requirement for a pre-termination hearing; and

(b) After Administrative Review, give Contractor written Legal Notice, of the decision affirming or reversing the proposed termination of this Contract and, for an affirming decision, the effective date of the termination; and

(c) After a decision affirming termination, give Members notice of the termination and information on their options for receiving services following the effective date of the termination, consistent with 42 CFR § 438.10; and

(d) After OHA has provided Contractor with Legal Notice that it has terminated its Contract under Sec. 9, Para. e, Sub. Para. (1) or intends to terminate this Contract under Sub. Para. (2, above of this Ex. D, OHA must give the affected Members written notice of OHA's intent to terminate this Contract and allow affected Members to Disenroll immediately without cause.

(5) Contractor's Right to Terminate for Cause. Contractor may terminate this Contract for cause if OHA is in default under Sec. 9, Para. c above of this Ex. D and fails to cure such default within the time specified therein.

(6) Contractor's Right to Terminate at its Discretion.

(a) No later than one hundred and four (104) days prior to the end of a Contract Year, other than Contract Year three, at the end of which this Contract will expire, OHA will provide Contractor's Contract Administrator with Administrative Notice of the changes to the terms and conditions of this Contract that are proposed to be made hereto for the subsequent Contract Year. At its sole discretion, Contractor shall have the right to terminate this Contract without cause for the following Contract Year effective as of the Renewal effective date. In order for termination to be effective hereunder, Contractor must provide OHA with written notice of such intent not less than ninety (90) days prior to the effective date of the Renewal Contract. Notice must be made via Legal Notice. A refusal by Contractor to enter into a Renewal Contract terminates this Contract, regardless of whether Contractor provided the Legal Notice described in this Sec. 9, Para. e, Sub. Para. (5) of this Ex. D. OHA and Contractor agree that, if Contractor terminates this Contract pursuant to this Sec. 9, Para. e, Sub. Para. (5) of this Ex. D, all other agreements between Contractor and OHA, including the Medicaid Contract and the Non-Medicaid Contract, will be terminated along with this Contract.

(b) If the Oregon Legislature adopts budgetary changes that require OHA to alter the rates under this Contract, OHA will prepare and offer Contractor a required amendment to the rates (the **"Required Rate Amendment"**). No later than one hundred and four (104) days prior to the effective date of the Required Rate Amendment, OHA will provide Contractor's Contract Administrator with Administrative Notice of the proposed changes to the. At its sole discretion, Contractor may terminate this Contract without cause by written Legal Notice to OHA not later than ninety (90) days prior to the effective date of the Required Rate Amendment, for termination effective as of the effective date of the Required Rate Amendment. A refusal by Contractor to enter into the Required Rate Amendment terminates this Contract, regardless of whether Contractor provided the Legal Notice described in this Sec. 9, Para. e, Sub. Para. (5) of this Ex. D and has the same effect as the failure to enter into a Renewal Contract.

(7) Notwithstanding Contractor's Legal Notice of termination or failure to enter into a Renewal Contract or the Required Rate Amendment under Sec. 9, Para. e, Sub. Para. (5) above of this Ex. D, OHA will have the right to require the Contract to remain in full force and effect and be amended as proposed by OHA until ninety (90) days after Contractor has, in accordance with the criteria prescribed by OHA, provided a Transition Plan in accordance with Sec. 10, Para. a below of this Ex. D.

(8) OHA may waive compliance with the deadlines in Sub. Paras. (5) and (6) of this Sec. 9, Para. e, of this Ex. D if OHA finds that the waiver of the deadlines is consistent with the effective and efficient administration of the services provided under this Contract and the protection of Members. If Contractor does not execute a Renewal Contract (or the Required Rate Amendment) or intends to not Renew (or not enter into the Required Rate Amendment), but fails to provide Legal Notice of non-Renewal (or fails to enter into the

2024 Required Rate Amendment) to OHA ninety (90) days prior to the date of any Renewal Contract, OHA will have the right to extend this Contract for the period of time OHA considers necessary, in its sole discretion, to accomplish the termination planning described in this Sec. 9, Para. e, Sub. Para (6) of this Ex. D.

(9) After receipt of Contractor's Notification of intent not to Renew (or not to enter into the Required Rate Amendment), or upon an extension of this Contract as described in Sub. Paras. (6) and (7) above of this Sec. 9, Para. e above of this Ex. D, OHA will issue written Notice to Contractor specifying the effective date of termination, Contractor's operational and reporting requirements, and timelines for submission of deliverables.

(10) Mutual Termination. This Contract may be terminated immediately upon mutual written consent of the parties or at such other time as the parties may agree in the written consent.

(11) Automatic Termination. This Contract will automatically be subject to termination under the condition described in Sec. 9, Para. a, Sub. Para. (7) and Para. e, Sub. Para. (6) above of this Ex. D (refusal to enter into an amended contract).

(12) The party initiating the termination shall provide written Legal Notice of termination to the other party and must specify the provision of this Contract giving the right to terminate, the circumstances giving rise to termination, and the date on which such termination is proposed to become effective.

10. Effect of Legal Notice of Termination, Non-Renewal, or Failure to Renew: Transition Plan

a. After providing or receiving Legal Notice of termination, or, in the case of expiration under Sec. 1.1.1 of the General Provisions to this Contract, at least ninety (90) days before the Expiration Date of this Contract, Contractor shall commence performing all of the Close-Out Requirements and Runout Activities set forth in this Sec. 10 and Sec. 11 of this Ex. D, and those set forth in OAR 410-141-3710, which includes Contractor drafting and providing to OHA, via Administrative Notice, with a Transition Plan. For purposes of clarity, any and all obligations required to be performed upon termination under this Sec. 10 of this Ex. D, shall also be required to be performed upon expiration. Contractor's Transition Plan shall include without limitation:

(1) Detail how Contractor will fulfill its continuing obligations under this Contract, including, without limitation, operational and reporting requirements, submitting deliverables as required by OHA and OAR 410-141-3710;

(2) Identifying a Transition Coordinator (with contact information) as OHA's single point of contact for all issues related to Contractor's Transition Plan;

(3) A list identifying the prioritization of high-needs Members for Care Coordination and any other Members requiring high level coordination;

(4) How and when Contractor will notify its Members, Providers, and Subcontractors of the termination of this Contract:

(a) Contractor shall include in the notices sent to Members information relating to Continuity of Care and how Members will be transitioned from Contractor to a new CCO without any disruption to the provision of services.

b. *The terms and conditions of Paragraph b of Section 10, Exhibit D in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.*

c. *The terms and conditions of Paragraph c of Section 10, Exhibit D in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein. Notwithstanding the foregoing, to the extent any provision in Paragraph c relates to Long Term Services and Supports, such provision(s) may be inapplicable.*

11. Effect of Termination or Expiration: Other Rights and Obligations

The terms and conditions of paragraphs a-c this Section 11, Exhibit D in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

d. If Contractor continues to provide services to a Member after the date of termination, OHA shall have no liability whatsoever to Contractor for the provision of such services. In addition, Contractor shall not have the right to seek reimbursement from any Member for the cost or value of any services received thereby after the date this Contract terminates. If Contractor chooses to provide services to a former Member who is no longer OHP eligible, neither OHA nor any such former member have any responsibility to pay for such services.

The terms and conditions of paragraphs e-f this Section 11, Exhibit D in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

12. Limitation of Liabilities

The terms and conditions of this Section 12, Exhibit D in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

13. Insurance

Contractor shall, from the Contract Effective Date through the date of termination or Expiration Date of this Contract, maintain insurance as set forth in Ex. F, attached hereto.

14. Transparency: Public Posting of Contractor Reports

The terms and conditions of this Section 14, Exhibit D in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

15. Access to Records and Facilities; Records Retention; Information Sharing

The terms and conditions of this Section 15, Exhibit D in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

16. Force Majeure

The terms and conditions of this Section 16, Exhibit D in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

17. Foreign Contractor

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

18. Assignment of Contract, Successors in Interest

The terms and conditions of Section 18, Exhibit D in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

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19. Subcontracts

The terms and conditions of this Section 19, Exhibit D in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

20. No Third Party Beneficiaries

The terms and conditions of this Section 20, Exhibit D in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

21. Amendments

a. OHA may amend this Contract to the extent provided herein, or in RFA OHA 4690-19, and to the extent permitted by Applicable Law. No amendment, modification, or change of terms of this Contract shall be binding on either Party unless made in writing and signed by both Parties and when required approved by the Oregon Department of Justice. Any such amendment, modification, or change, if made, shall be effective only in the specific instance and for the specific purpose given.

b. Contractor understands, acknowledges, and agrees that many, if not all, of Contractor's obligations under this Contract with respect to drafting and implementing policies, procedures, and work plans, as well as data collection and reporting, and other similar deliverables, mirror those obligations under the Medicaid Contract. In order to avoid unnecessary duplication of efforts, the parties will, upon request of OHA, enter into a memorandum of understanding wherein the obligation to draft and submit separate policies, procedures, and work plans as well as data collection and reporting, and other similar deliverables will be identified with particularity and where not so identified, Contractor and OHA shall deem the obligation met under this Contract when it is met under the Medicaid Contract.

c. OHA may, from time to time, require Contractor to enter into an amendment to this Contract under any of the following circumstances:

(1) Due to changes in Applicable Laws including changes in Covered Services and CCO Payments under ORS 414.735, or if failure to amend this Contract to effectuate those changes proposed in the amendment may place OHA at risk of non-compliance with Applicable Law or the requirements of the Legislature or Legislative Emergency Board;

(2) To address budgetary constraints, including those arising from changes in funding, appropriations, limitations, allotments, or other expenditure authority limitations provided in Sec. 6 of this Ex. D;

(3) To reduce or expand the Service Area, or reduce or expand the Enrollment limit, or both, and any CCO Payment Rate change as may be necessary to align with the expansion or reduction thereof and which will be made in accordance with Ex. C, Sec. 3 of this Contract; and

(4) To provide additional information regarding Contractor's obligations to: (i) collect and report data, and (ii) submit policies, procedures, handbooks, guidebooks, and the like.

d. Failure of Contractor to enter into an amendment described in Para, c above as necessary for the Amendment to go into effect on its proposed effective date, is a default of Contractor under Sec. 9, Para. a, Sub. Para. (8) of this Ex. D.

e. 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 approving such changes. Any

changes required by federal or State law or regulation shall take effect not later than the effective date of the federal or State law or regulation.

22. Waiver

The terms and conditions of this Section 22, Exhibit D in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

23. Severability

The terms and conditions of this Section 23, Exhibit D in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

24. Survival

All rights and obligations cease upon termination or expiration of this Contract, except for the rights and obligations, and declarations which expressly or by their nature survive termination of this Contract, including without limitation the following Sections or provisions set forth below in this Sec. 24. Without limiting the forgoing or anything else in this Contract, in no event shall Contract expiration or termination extinguish or prejudice OHA's right to enforce this Contract with respect to any default by Contractor that has not been cured.

a. Exhibit A, Definitions

b. General Provisions: Secs. 4 and 5

c. Exhibit D: Secs. 1, 4 through 13, 15, 16, 18 through 29, 31.

d. Exhibit E: Sec. 6, HIPAA Compliance (but excluding paragraph d) shall survive termination for as a long as Contractor holds, stores, or otherwise preserves Individually Identifiable Health Information of Members or for a longer period if required under Sec. 12 of this Ex. D.

e. Exhibit N shall survive termination for the period of time that Contractor retains any Access (as such term is defined in Sec. 2.1 of Ex. N) to OHA or State Data, Network and Information Systems, and Information Assets.

f. Special Terms and Conditions:

In addition to any other provisions of this Contract that by their context are meant to survive Contract expiration or termination, the following special terms and conditions survive Contract expiration or termination, for a period of two (2) years unless a longer period is set forth in this Contract:

(1) Claims Data

(a) The submission of all Encounter Data for services rendered to Contractor's Members during the contract period;

(b) Certification that Contractor attests that the submitted encounter claims are complete, truthful and accurate to the best knowledge and belief of Contractor's authorized representative, subject to False Claims Act liability;

(c) Adjustments to encounter claims in the event Contractor receives payment from a Member's Third Party Liability or Third Party recovery; and

(d) Adjustments to encounter claims in the event Contractor recovers any Provider Overpayment from a Provider.

(2) Financial Reporting

(a) Quarterly financial statements as defined in Ex. L;

(b) Audited annual financial statements as defined in Ex. L;

(c) Submission of details related to ongoing Third Party Liability and Third Party recovery activities by Contractor or its Subcontractors; and

(d) Data related to the calculation of quality and performance metrics.

(3) Operations

(a) Point of contact for operations while transitioning;

(b) Claims processing;

(c) Provider and Member Grievances and Appeals; and

(d) Implementation of and any necessary modifications to the Transition Plan.

(4) Corporate Governance

(a) Oversight by Governing Board and Community Advisory Council;

(b) Not initiating voluntary bankruptcy, liquidation, or dissolution;

(c) Maintenance of all licenses, certifications, and registrations necessary to do the business of a CCO in Oregon; and

(d) Responding to subpoenas, investigations, and governmental inquiries.

(5) Financial Obligations

The following requirements survive Contract expiration or termination indefinitely:

(a) Reconciliation of Risk Corridor Payments;

(b) Reconciliation and right of setoffs;

(c) Recoupment of capitation paid for Members deemed ineligible or who were enrolled into an incorrect benefit category; and

(d) Recoupment (by means of setoff or otherwise) of any identified Overpayment.

(6) Sanctions and Liquidated Damages

(a) Contract expiration or termination does not limit OHA's ability to impose Sanction or Liquidated Damages for the failures or acts (or both) as set out in Ex. B, Part 9.

(b) The decision to impose a Sanction or Liquidated Damages does not prevent OHA from imposing additional Sanctions at a later date.

Sanctions imposed on Contractor after Contract expiration or termination will be reported to CMS according to the requirements set out in Ex. B, Part 9.

25. Legal Notice; Administrative Notice

The terms and conditions of Section 25, Exhibit D in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

26. Construction

The terms and conditions of this Section 26, Exhibit D in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

27. Headings and Table of Contents

The terms and conditions of this Section 27, Exhibit D in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

28. Merger Clause

The terms and conditions of this Section 28, Exhibit D in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

29. Counterparts

The terms and conditions of this Section 29, Exhibit D in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

30. Equal Access

The terms and conditions of this Section 30, Exhibit D in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

31. Media Disclosure

The terms and conditions of this Section 31, Exhibit D in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

32. Mandatory Reporting of Abuse

The terms and conditions of this Section 32, Exhibit D in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

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Exhibit E – Required Federal Terms and Conditions

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

1. Miscellaneous Federal Provisions

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

2. Equal Employment Opportunity

If this Contract, including Amendments, is for more than $10,000, then Contractor shall comply and require all Subcontractors to comply with Executive Order 11246, entitled "Equal Employment Opportunity," as amended by Executive Order 11375, and as supplemented in Department of Labor regulations (41 CFR Part 60).

3. Clean Air, Clean Water, EPA Regulations

If this Contract, including Amendments, exceeds $100,000 then Contractor shall comply and require all Subcontractors to comply with all applicable standards, orders, or requirements issued under Section 306 of the Clean Air Act (42 USC. 7606), the Federal Water Pollution Control Act as amended (commonly known as the Clean Water Act) (33 USC. 1251 to 1387), specifically including, but not limited to Section 508 (33 USC 1368), Executive Order 11738, and Environmental Protection Agency regulations (2 CFR Part 1532), which prohibit the use under non-exempt federal contracts, grants or loans of facilities included on the EPA List of Violating Facilities. Violations shall be reported in writing to: (a) OHA via Administrative Notice; (b) United States Department of Health and Human Services; and (c) the appropriate Regional Office of the federal Environmental Protection Agency. Contractor shall include and require all Subcontractors to include in all contracts with Subcontractors receiving more than $100,000, language requiring the Subcontractor to comply with the federal laws identified in this section.

4. Energy Efficiency

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

5. Truth in Lobbying

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

a. No federal appropriated funds have been paid or will be paid, by or on behalf of Contractor, to any Person for influencing or attempting to influence an officer or employee of an agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan or cooperative agreement.

b. If any funds other than federal appropriated funds have been paid or will be paid to any Person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with this federal contract, grant, loan or cooperative agreement, Contractor shall complete and submit Standard Form LLL, "Disclosure Form to Report Lobbying" in accordance with its instructions.

c. Contractor shall require that the language of the certification made under this Sec. 5 of this Ex. E be included in the award documents for all subawards at all tiers (including Subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients and Subcontractors shall certify and disclose accordingly.

d. The certification made under this Sec. 5 of this Ex. E is a material representation of fact upon which reliance was placed when this Contract was made or entered into. Submission of this certification is a prerequisite for making or entering into this Contract imposed by Section 1352, Title 31, of the U.S. Code. Any Person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

e. No part of any federal funds paid to Contractor under this Contract shall be used other than for normal and recognized executive legislative relationships, for publicity or propaganda purposes, for the preparation, distribution, or use of any kit, pamphlet, booklet, publication, electronic communication, radio, television, or video presentation designed to support or defeat the enactment of legislation before the United States Congress or any State or local legislature itself, or designed to support or defeat any proposed or pending regulation, administrative action, or order issued by the executive branch of any State or local government itself.

f. No part of any federal funds paid to Contractor under this Contract shall be used to pay the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or executive order proposed or pending before the United States Congress or any State government, State legislature or local legislature or legislative body, other than for normal and recognized executive-legislative relationships or participation by an agency or officer of a State, local or tribal government in policymaking and administrative processes within the executive branch of that government.

g. The prohibitions in Paras. e and f of this Section shall include any activity to advocate or promote any proposed, pending or future Federal, State or local tax increase, or any proposed, pending, or future requirement or restriction on any legal consumer product, including its sale or marketing, including but not limited to the advocacy or promotion of gun control.

h. No part of any federal funds paid to Contractor under this Contract may be used for any activity that promotes the legalization of any drug or other substance included in schedule I of the schedules of controlled substances established under Section 202 of the Controlled Substances Act except for normal and recognized executive congressional communications. This limitation shall not apply when there is significant medical evidence of a therapeutic advantage to the use of such drug or other substance of that federally sponsored clinical trials are being conducted to determine therapeutic advantage.

6. HIPAA Compliance

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

a. Privacy and Security of Individually Identifiable Health Information. Individually Identifiable Health Information about specific individuals is protected from unauthorized use or disclosure consistent with the requirements of HIPAA. Individually Identifiable Health Information relating to specific individuals may be exchanged between Contractor and OHA for purposes directly related to the provision of services to Members which are funded in whole or in part under this Contract. However, Contractor shall not use or disclose any Individually Identifiable Health Information about specific individuals in a manner that would violate HIPAA Privacy Rules in 45 CFR Parts 160 and 164, OHA Privacy Rules, OAR Chapter 407 Division 14, and OAR Chapter 943, Division 14, or OHA Notice of Privacy Practices, if done by OHA. A copy of the most recent OHA Notice of Privacy Practices is posted on the OHA web site at: https://sharedsystems.dhsoha.state.or.us/forms/, Form number ME2090 Notice of Privacy Practices, or may be obtained from OHA.

b. HIPAA Information Security. Contractor shall adopt and employ reasonable administrative, technical, and physical safeguards required by HIPAA Privacy Rules in 45 CFR Parts 160 and 164, OAR Chapter 407, Division 14, and OAR Chapter 943, Division 14, and OHA Notice of Privacy Practices to ensure that Member Information shall be used by or disclosed only to the extent necessary for the permitted use or disclosure and consistent with Applicable Laws and the terms and conditions of this Contract. Incidents involving the privacy or security of Member Information must be immediately reported, but no later than one (1) Business Days after discovery, via Administrative Notice, to the Privacy Compliance Officer in OHA's Information Security and Privacy Office (ISPO) at DHS.PrivacyHelp@odhsoha.oregon.gov, with a follow-up telephone call to ISPO's Privacy Reporting Line at 503-945-5780.

c. Data Transactions Systems. Contractor shall comply with the HIPAA standards for electronic transactions published in 45 CFR Part 162 and the OHA EDT Rules, 943-120-0100 through 943-120-0200. In order for Contractor to exchange electronic data transactions with OHA in connection with claims or Encounter Data, eligibility or Enrollment information, authorizations or

other electronic transaction, Contractor shall execute an EDT Trading Partner Agreement with OHA and shall comply with the OHA EDT Rules.

d. Consultation and Testing. If Contractor reasonably believes that Contractor's or OHA's data transactions system or other application of HIPAA privacy or security compliance policy may result in a violation of HIPAA requirements, Contractor shall promptly consult the OHA HIPAA officer. Contractor or OHA may initiate a request for testing of HIPAA transaction requirements, subject to available resources and OHA testing schedule.

7. Resource Conservation and Recovery

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

8. Audits

a. Contractor shall comply, and require all Subcontractors to comply, with applicable audit requirements and responsibilities set forth in this Contract and Applicable Law.

b. If Contractor expends $750,000 or more in federal funds (from all sources) in a federal fiscal year, Contractor shall have a single organization-wide audit conducted in accordance with the provisions of 2 CFR Subtitle B with guidance at 2 CFR Part 200. Copies of all audits must be provided, via Administrative Notice, to OHA, within thirty (30) days of completion. If Contractor expends less than $750,000 in a federal fiscal year, Contractor is exempt from Federal audit requirements for that year. Records must be available as provided in Ex. B, Part 8, Sec. 3, "Access to Records."

c. Contractor must cooperate with OHA in OHA's compliance with audit requirements and responsibilities applicable to OHP Bridge, as set forth in 42 CR Part 600, Subpart H.

9. Debarment and Suspension

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

a. The Provider is Controlled by a Sanctioned individual.

b. The Provider has a contractual relationship that provides for the administration, management or provision of Medical Services, or the establishment of policies, or the provision of operational support for the administration, management or provision of Medical Services, either directly or indirectly, with an individual convicted of certain crimes as described in section 1128(b)(8)(B) of the Social Security Act.

c. The Provider employs or contracts, directly or indirectly, for the furnishing of health care, Utilization Review, medical social work, or administrative services, with one of the following:

(1) Any individual or entity excluded from participation in federal health care programs.

(2) Any entity that would provide those services through an excluded individual or entity.

d. The Contract prohibits Contractor from knowingly having a Person with ownership of 5% or more of Contractor's equity if such Person is (or is Affiliated with a Person or entity that is) debarred, suspended, or excluded from participation in federal healthcare programs.

e. If OHA learns that Contractor has a prohibited relationship with a Person or entity that is debarred, suspended, or excluded from participation in federal healthcare programs, OHA:

(1) Must notify DHHS of Contractor's noncompliance;

(2) May continue an existing agreement with Contractor unless DHHS directs otherwise; and

(3) Shall have the right not to Renew or extend this Contract with Contractor unless DHHS provides to the State a written statement describing compelling reasons that exist for Renewing or extending this Contract, consistent with 42 CFR 438.610.

10. [RESERVED]

11. Additional OHP Bridge, Medicaid and CHIP Requirements

Contractor shall comply with all Applicable Laws pertaining to the provision of OHP Bridge Covered Services under Section 1331 of the Patient Protection and Affordable Care Act of 2010 and 42 CFR Part 600. Contractor shall comply with all Applicable Laws pertaining to the provision of OHP services under the Medicaid Act, Title XIX, 42 USC Section 1396 et seq., and CHIP benefits established by Title XXI of the Social Security Act, including without limitation:

a. Keep such Records as are necessary to fully disclose the extent of the services provided to individuals receiving OHP assistance and shall furnish such information to any State or federal agency responsible for administering the OHP program regarding any payments claimed by such Person or institution for providing OHP services as the State or federal agency may from time to time request. 42 USC Section 1396a(a)(27); 42 CFR § 431.107(b)(1) & (2); and 42 CFR § 457.950(a)(3).

b. Comply with all disclosure requirements of 42 CFR § 1002.3(a); 42 CFR § 455 Subpart (B); and 42 CFR § 457.900(a)(2).

c. Certify when submitting any claim for the provision of OHP services that the information submitted is true, accurate and complete. Contractor shall acknowledge Contractor's understanding that payment of the claim will be from federal and State funds and that any falsification or concealment of a material fact may be prosecuted under federal and State laws.

12. Agency based Voter Registration

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

13. Clinical Laboratory Improvements

Contractor shall and shall ensure that any Laboratories used by Contractor shall comply with the Clinical Laboratory Improvement Amendments (CLIA 1988), 42 CFR Part 493 Laboratory Requirements and ORS 438 (Clinical Laboratories, which require that all Laboratory testing sites providing services under

this Contract shall have either a Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number. Those Laboratories with certificates of waiver will provide only the eight types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of Laboratory tests.

14. Advance Directives

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

a. Their rights under Oregon law; and

b. Contractor's policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of Advance Directives as a matter of conscience.

c. Contractor shall inform Members that complaints concerning noncompliance with the Advance Directive requirements may be filed with OHA.

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

15. Practitioner Incentive Plans

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

16. Risk HMO

If Contractor is a Risk HMO and is Sanctioned by CMS under 42 CFR 438.730, Payments provided for under this Contract will be denied for Members who enroll after the imposition of the Sanction, as set forth under 42 CFR 438.726.

17. Conflict of Interest Safeguards

a. Contractor shall not offer, promise, or engage in discussions regarding future employment or business opportunity with any ODHS or OHA employee (or their relative or Member of their household), and no ODHS or OHA employee shall solicit, accept or engage in discussions regarding future employment or business opportunity, if such ODHS or OHA employee participated personally and substantially in the procurement or administration of this Contract as a ODHS or OHA employee.

b. Contractor shall not offer, give, or promise to offer or give to any ODHS or OHA employee (or any relative or Member of their household), and such employees shall not accept, demand, solicit, or receive any gift or gifts with an aggregate value in excess of $50 during a calendar year or any

gift of payment of expenses for entertainment. "Gift" for this purpose has the meaning defined in ORS 244.020 and OAR 199-005-0001 to 199-005-0030.

c. Prior to the award of any replacement contract, Contractor shall not solicit or obtain, from any ODHS or OHA employee, and no ODHS or OHA employee may disclose, any proprietary or source selection information regarding such procurement, except as expressly authorized by the Director of OHA or ODHS.

d. Contractor shall not retain a former ODHS or OHA employee to make any communication with or appearance before OHA on behalf of Contractor in connection with this Contract if that Person participated personally and substantially in the procurement or administration of this Contract as a ODHS or OHA employee.

e. If a former ODHS or OHA employee authorized or had a significant role in this Contract, Contractor shall not hire such a Person in a position having a direct, beneficial, financial interest in this Contract during the two-year period following that Person's termination from ODHS or OHA.

f. Contractor shall develop and maintain (and update as may be needed from time to time) a Conflict of Interest Safeguards Handbook wherein Contractor shall set forth appropriate, written policies and procedures to avoid actual or potential conflict of interest involving Members, ODHS, or OHA employees, and Subcontractors. These policies and procedures shall include, at a minimum, safeguards:

(1) against Contractor's disclosure of Applications, bids, proposal information, or source selection information; and

(2) requiring Contractor to:

(a) promptly report, but in no event seven (7) Business Days after impermissible contact, any contact with a Contractor, bidder, or offeror in writing, via Administrative Notice, to OHA's Contract Administrator; and

(b) reject the any offer or proposed offer of employment; or disqualify itself from further personal and substantial participation in the procurement if Contractor contacts or is contacted by a Person who is a contractor, bidder, or offeror in a procurement involving federal funds regarding possible employment for Contractor.

g. Contractor shall provide OHA its Conflict of Interest Safeguards Handbook within five (5) Business Days of OHA's request or at the request of: (i) the Oregon Secretary of State; (ii) the federal government's Office of Inspector General; (iii) the federal Government Accountability Office; (iv) CMS; and (v) any other authorized state or federal reviewers, for the purposes of audits or inspections. The foregoing agencies shall have the right to review and approve or disapprove such Handbook for compliance with this Sec. 17 of this Ex. E which shall be provided to Contractor within thirty (30) days of receipt. In the event OHA disapproves of the Conflict of Interest Safeguards Handbook, Contractor shall, in order to remedy the deficiencies in such Handbook, follow the process set forth in Sec. 5, Ex. D of this Contract.

h. The provisions of this Sec. 17 of Ex. E, Conflict of Interest Safeguards, are intended to be construed to assure the integrity of the procurement and administration of this Contract. For purposes of this Sec. 17:

(1) "Contract" includes any Predecessor CCO Contract or other similar contract between Contractor and OHA.

(2) Contractor shall apply the definitions in the State Public Ethics Law, ORS 244.020, for "actual conflict of interest," "potential conflict of interest," "relative," and "Member of household."

(3) "Contractor" for purposes of this section includes all Contractor's Affiliates, assignees, subsidiaries, parent companies, successors and transferees, and persons under common Control with Contractor; any officers, directors, partners, Agents and employees of such Person; and all others acting or claiming to act on their behalf or in concert with them.

(4) "Participates" means actions of a ODHS or OHA employee, through decision, approval, disapproval, recommendation, the rendering of advice, investigation or otherwise in connection with the Contract.

(5) "Personally and substantially" has the same meaning as "personal and substantial" as set forth in 5 CFR §2635.402(b)(4).

18. Non-Discrimination

Contractor shall comply, and require its Subcontractors to comply, with all federal and State laws and regulations including Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972 (regarding education programs and activities) the Age Discrimination Act of 1975, the Rehabilitation Act of 1973, the Americans with Disabilities Act (ADA) of 1990, Section 1557 of the ACA and all amendments to those acts and all regulations promulgated thereunder. Contractor shall also comply with all applicable requirements of State civil rights and rehabilitation statutes and rules.

19. OASIS

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

20. Patient Rights Condition of Participation

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

21. Federal Grant Requirements

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

a. Part 74, including Appendix A (uniform federal grant administration requirements);

b. Part 92 (uniform administrative requirements for grants to state, local and tribal governments);

c. Part 80 (nondiscrimination under Title VI of the Civil Rights Act);

d. Part 84 (nondiscrimination on the basis of handicap);

e. Part 91 (nondiscrimination on the basis of age);

f. Part 95 (Medicaid and CHIP federal grant administration requirements); and

g. Contractor shall not expend, and Contractor shall include a provision in any Subcontract that its Subcontractor shall not expend, any of the funds paid under this Contract for roads, bridges, stadiums, or any other item or service not covered under the OHP.

22. Mental Health Parity

Contractor shall adhere to CMS guidelines regarding Mental Health Parity in accordance with 42 CFR Part 438, Subpart K detailed below and comply with the Mental Health Parity reporting requirements specified in Sec. 25 of Ex. M of this Contract:

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

b. If Contractor includes an aggregate lifetime or annual dollar limit on at least two-thirds of all medical/surgical benefits provided to Members, it must either apply the aggregate lifetime or annual dollar limit both to the medical/surgical benefits to which the limit would otherwise apply and to mental health or substance use disorder benefits in a manner that does not distinguish between the medical/surgical benefits and mental health or substance use disorder benefits; or not include an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is more restrictive than the aggregate lifetime or annual dollar limit, respectively, on medical/surgical benefits;

c. If Contractor includes an aggregate lifetime limit or annual dollar amount that applies to one-third or more but less than two-thirds of all medical/surgical benefits provided to Members, it must either impose no aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits; or impose an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is no more restrictive than an average limit calculated for medical/surgical benefits in accordance with 42 CFR § 438.905(e)(ii);

d. Contractor shall not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification furnished to Members (whether or not the benefits are furnished by Contractor);

e. If a Member is provided mental health or substance use disorder benefits in any classification of benefits (inpatient, Outpatient, emergency care, or prescription drugs), mental health or substance use disorder benefits must be provided to the Member in every classification in which medical/surgical benefits are provided;

f. Contractor may not apply any cumulative financial requirements for mental health or substance use disorder benefits in a classification (inpatient, Outpatient, emergency care, prescription drugs) that accumulates separately from any established for medical/surgical benefits in the same classification;

g. Contractor may not apply more stringent utilization or Prior Authorization standards to mental health or substance use disorder, then standards that are applied to medical/surgical benefits;

h. Contractor may not impose Non-Quantitative Treatment Limitations (NQTLs) for mental health or substance use disorder benefits in any classification unless, under the policies and procedures of Contractor as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health or substance use disorder benefits in the

classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits in the classification;

i. Contractor shall provide all necessary documentation and reporting required by OHA to establish and demonstrate compliance with 42 CFR part 438, subpart K regarding parity in mental health and substance use disorder benefits;

j. Contractor shall use processes, strategies, evidentiary standards or other factors in determining access to out of Network Providers for mental health or substance use disorder benefits that are comparable to and applied no more stringently than, the processes, strategies, evidentiary standards or other factors in determining access to out of Network Providers for medical/surgical benefits in the same classification.

23. Effect of Loss of Program Authority

Should any part of the scope of work under this Contract relate to a State program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), Contractor must do no work on that part after the effective date of the loss of program authority. The State must adjust Capitation Rates to remove costs that are specific to any program or activity that is no longer authorized by law. If Contractor works on a program or activity no longer authorized by law after the date the legal authority for the work ends, Contractor will not be paid for that work. If the State paid Contractor in advance to work on a no-longer-authorized program or activity and under the terms of this Contract the work was to be performed after the date the legal authority ended, the payment for that work should be returned to the State. However, if Contractor worked on a program or activity prior to the date legal authority ended for that program or activity, and the State included the cost of performing that work in its payments to Contractor, Contractor may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

24. ACA Section 1557 Coordinator

a. As required by Section 1557 of the ACA, if Contractor employs fifteen (15) or more persons, then Contractor must designate and authorize at least one (1) employee to coordinate Contractor's compliance with its responsibilities under Section 1557 in its health programs and activities, including the investigation of any grievance communicated to it alleging noncompliance with Section 1557 or alleging any action that would be prohibited by Section 1557 (**"Section 1557 Coordinator"**). As appropriate, Contractor may assign one or more designees to carry out some of these responsibilities, but the Section 1557 Coordinator must retain ultimate oversight for ensuring coordination with Contractor's compliance.

b. Contractor must ensure that, at minimum, its Section 1557 Coordinator:

(1) Receives, reviews, and processes grievances, filed under the grievance procedure as set forth in § 92.8(c);

(2) Coordinates Contractor's recordkeeping requirements as set forth in § 92.8(c);

(3) Coordinates effective implementation of Contractor's language access procedures as set forth in § 92.8(d);

(4) Coordinates effective implementation of Contractor's effective communication procedures as set forth in § 92.8(e);

(5) Coordinates effective implementation of Contractor's reasonable modification procedures as set forth in § 92.8(f); and

(6) Coordinates training of relevant employees as set forth in § 92.9, including maintaining documentation required by such section.

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Exhibit F – Insurance Requirements

The terms and conditions of Exhibit F in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

[Remainder of page intentionally left blank]

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

1. Delivery System Network Provider Monitoring and Reporting Overview

a. Contractor shall employ or enter into Network Provider agreements with, in accordance with the standards set forth in CFR § 438.206, Ex. B, Part 4 and any other applicable provisions of this Contract, enough Providers to meet the needs of its Members in all categories of service, and types of service Providers, such that Members have timely and appropriate access to services. Contractor shall develop its Provider Network that is consistent with 42 CFR § 438.68, 42 CFR § 457.1230, and OAR 410-141-3515. Contractor shall only employ or otherwise contract with Providers who agree to provide services to Non-Medicaid, COFA, Veteran, and Medicaid Members and who comply with all applicable state and federal non-discrimination laws including, without limitation, ORS 659A.440 through 659A.409 and the federal Civil Rights Act. Contractor shall incorporate the priorities from its Community Health Assessment, its Community Health Improvement Plan, and Transformation and Quality Strategy such that Contractor's Provider Network is capable of providing integrated and coordinated physical, Oral Health, Behavioral Health, and Substance Use Disorders treatment services and supports as required under this Contract.

b. If necessary to ensure access to an adequate Provider Network, Contractor may be required to contract with Providers located outside of the defined Service Area.

c. Contractor shall Monitor, document, report and evaluate its Provider Network as set forth in this Ex. G.

d. Contractor's obligations under Para. c, above of this Ex. G, shall include the development of a system and methodology for Monitoring and evaluating Member access including, but not limited to, the availability of Network Providers within time and distance standards, adherence to standards for wait time to appointment for primary care, specialty care, and Behavioral Health services, and sufficiency of language services and physical accessibility.

e. Contractor shall promptly and fully remedy any Provider Network deficiencies identified through the course of self-assessment, in the event of a Material Change, or as a result of OHA Monitoring, or EQRO review under the Medicaid Contract.

f. The accuracy of data and completeness submitted in the quarterly DSN Provider Capacity Report will be periodically validated against available sources. If Provider data is submitted in an invalid format or contains invalid values for required data elements or both, OHA shall have the right to require Contractor to correct its data. If data errors are persistent, as defined by OHA, OHA shall have the right to require Contractor to, in addition to correcting its data, provide monthly DSN Provider Capacity Reports to OHA, and OHA shall have the right to pursue any and all of its rights and remedies under this Contract.

g. If any activities have been Subcontracted, Contractor shall also describe the maintenance, reporting, and Monitoring and its oversight procedures to ensure compliance with the requirements of this Contract and Provider Network adequacy.

2. Delivery System Network Provider Monitoring and Reporting Requirements

The terms and conditions of Section 2, Exhibit G in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

3. Cooperative Agreements with Publicly Funded Programs

The terms and conditions of Section 3, Exhibit G in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

4. [RESERVED]

5. Hospital Network Adequacy

The terms and conditions of Section 5, Exhibit G in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

[Remainder of page intentionally left blank]

Exhibit H – Value-Based Payment

Contractor shall demonstrate, as specified below, how it will use Value-Based Payment (VBP) methodologies alone or in combination with delivery system changes to achieve the Triple Aim Goals of better care, controlled costs, and better health for Members.

Contractor is not required to compensate any providers providing services to BHP Members utilizing the Value Based Payment methodology under this Contract.

However, Contractor may, if it so chooses, compensate its providers providing services to BHP Members utilizing the Value Based Payment methodology. In the event Contractor does so, Contractor may include any such payments made under this Contract in its VBP reporting obligations under the Medicaid Contract.

1. [RESERVED]

2. [RESERVED]

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

a. For Contract Year two (2025), Contractor shall continue to provide per-member-per-month (PMPM) payments to PCPCH clinics established during Contract Years one through three (2024-2026). Contractor shall provide PMPM payments to its PCPCH clinics as a supplement to any other payments made to PCPCHs, be they Fee-for-Service or VBPs. Contractor shall also vary the PMPMs such that higher-tier PCPCHs receive higher payments than lower-tier PCPCHs. The PMPM payments must be in amounts that are material and increase each of the three Contract Years of this Contract. OHA's VBP Technical Guide will include guidance to assist Contractor in complying with these requirements.

b. The PCPCH PMPM payment counted for this requirement must be at a LAN Category 2A (Foundational Payments for Infrastructure & Operations) level, as defined by the LAN Framework. Unless combined with a LAN Category 2C VBP or higher, such payment arrangements shall not count toward Contractor's annual CCO VBP minimum threshold or Contractor's annual VPB targets.

4. [RESERVED]

5. [RESERVED]

6. [RESERVED]

7. [RESERVED]

[Remainder of page intentionally left blank]

Exhibit I – Grievance and Appeal System

The terms and conditions of Exhibit I in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

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Exhibit J – Health Information Technology

The terms and conditions of Exhibit J in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

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Exhibit K – Social Determinants of Health and Equity

1. Community Advisory Council

To ensure that the health care needs of all Members of the Community within Contractor's Service Area are being addressed, Contractor shall ensure that its Community Advisory Council, established in accordance with ORS 414.575, advises Contractor on such matters specific to the OHP Bridge – BHP Members.

2. Community Advisory Council Membership

The terms and conditions of Section 2, Exhibit K in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

3. Community Advisory Council Meetings

The terms and conditions of Section 3, Exhibit K in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

4. Duties of the CAC

The terms and conditions of Section 4, Exhibit K in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

5. Contractor's Annual CAC Demographic Report

The terms and conditions of Section 5, Exhibit K in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

6. Community Health Assessment

The terms and conditions of Section 6, Exhibit K in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

7. Community Health Improvement Plan

The terms and conditions of Section 7, Exhibit K in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

8. [RESERVED]

9. Health-Related Services

The terms and conditions of Section 9, Exhibit K in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

10. Health Equity Plans

The terms and conditions of Section 10, Exhibit K in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

11. Traditional Health Workers

The terms and conditions of Section 11, Exhibit K in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

12. REALD Data Collection

The terms and conditions of Section 12, Exhibit K in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

Exhibit L – Solvency Plan, Financial Reporting, and Sustainable Rate of Growth

1. Overview of Solvency Plan

The terms and conditions of Section 1, Exhibit L in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

2. Financial Responsibility; Allowable Expenses and Costs

a. In keeping with Contractor's obligations under Sec. 1, Para. c above of this Ex. L, and in keeping with the State's goals, as set out in ORS 414.018, 414.570, and 442.386, which include, without limitation, (i) increasing the quality, reliability, and continuity of care, (ii) ensuring the long-term affordability and financial sustainability of the State's health care system, and (iii) advancing the use of health information technology to achieve the foregoing goals as well as many others, Contractor must ensure all costs and expenses are necessary for Contractor's business operations and rationally related to serving the goals of the State.

b. Contractor shall be subject to oversight authority from the trustees of the BHP Trust Fund, and must comply with all requests made by any of the trustees of the BHP Trust Fund for records, receipts, or other information necessary to enable the trustees to effect appropriate oversight over the appropriate use of the BHP Trust Fund, as required by Section 1331 of the Patient Protection and Affordable Care Act of 2010 and 42 CFR Part 600. The trustees of the BHP Trust Fund are the duly authorized representatives of OHA and as such shall have the same rights to request and have access to Contractor's Records that OHA has under Sec. 15 of Exhibit D to this Contract.

c. Contractor shall ensure all annual executive and director level compensation (including fringe benefits), that is reported to OHA as an allowable administrative expense to be included in the development of capitation rates is (i) reasonable for the actual services rendered, (ii) conforms to the established, written policies of Contractor, and (iii) is not in excess of the benchmark compensation amount determined applicable for the fiscal year by the Office of Federal Procurement Policy adjusted annually to reflect the change in the Employment Cost Index for private industry workers in service producing industries as calculated by the Bureau of Labor Statistics. For purposes of this Para. a, "Compensation" means the total amount of wages, salary, bonuses, deferred compensation (including securities), and fringe benefits, whether paid, earned, or otherwise accruing during a calendar year. Fringe benefits include, without limitation, the costs of vacation, personal, and sick leave, insurance benefits (life, health, etc.), retirement benefits, and severance pay. In the event OHA determines Contractor has failed to report the compensation of its executives and directors in accordance with the criteria set forth in this Para. a, OHA shall have the right to determine the allowable reportable compensation that will be used in the development of capitation rates.

d. Contractor shall ensure all transactions (including, without limitation, those for management, professional, consulting, and other services, for real or personal property, equipment, supplies, and financing) that are reported to OHA as allowable reportable expenses to be included in the development of capitation rates (i) are reasonably necessary for the operation of the CCO, (ii) comply with Contractor's established, written procurement policies and procedures, and (iii) do not impair or otherwise compromise (w) Contractor's obligation to provide Covered Services to its Members, (x) the ability of Contractor to recruit, retain, employ, or contract with sufficient numbers of Providers or health care practitioners (physical, behavioral, and oral health, THWs, etc.), or both, to achieve network adequacy in a manner that reflects and meets the needs of the diversity of populations within Contractor's Service Area, (y) the implementation and use of EHRs

throughout its Provider Network as set forth in its HIT Roadmap, and (z) any other obligations of Contractor under this Contract.

(1) Except as provided in Sub. Para. (2) below of this Para. b, and in addition to the requirements set for in Para. b above of this Sec. 2, all transactions with, or payments to, a Related Party that are reported to OHA as allowable expenses to be included in the development of capitation rates must be valued at the Cost to the Related Party, not to exceed the Fair Market Value of comparable services, property, equipment, or supplies that could be purchased elsewhere and resulting from an arm's length transaction. However, if the Fair Market Value for comparable services, property, equipment or supplies is lower than the Costs of the Related Party, the allowable reported expense shall not exceed the Fair Market Value.

(2) Notwithstanding Sub. Para. (1) above of this Para. b, an exception may be provided if the Contractor demonstrates by convincing evidence, as reasonably determined by OHA, that: (i) the service provider, supplier of equipment or supplies, property owner, or financing organization (individually and collectively, "Vendor") is a bona fide separate organization; (ii) a substantial part of the Vendor's business activity with Contractor is transacted with third-parties that are not related to the Vendor by common ownership or control and there is an open, competitive market for the type of services, property, equipment, or supplies offered by the Vendor; (iii) the charge to Contractor by the Vendor is in line with the charge for the services, property, equipment, or supplies offered on the open market and is no more than the charge made under comparable circumstances to others by the Vendor for such services, property, equipment, or supplies. In such event, the charge by the Related Party to Contractor for such service, property, equipment, or supplies is allowable at Cost.

(3) In the event OHA determines Contractor has failed to report transactions in accordance with the criteria set forth in this Para. b, OHA shall have the right to determine the allowable reportable sums that will be used in the development of capitation rates.

(4) For the purpose of this Para. b, "Cost" means the expenditure required to create or sell services, property, equipment, or supplies, without any mark-up for profit.

(5) For the purpose of this Para. b, "Fair Market Value" means the price payable for comparable services, property, equipment, or supplies which could be purchased elsewhere, resulting from an arm's length transaction entered into by willing buyers and willing sellers, neither being under any compulsion to purchase or sell and both having reasonable knowledge of the facts.

e. Contractor shall include in each contract, agreement, and purchase order entered into with, and issued to, every Vendor the obligation to comply with any and all requests for information, records, and documents requested by Contactor (and identified by OHA) as may be necessary to be granted an exception under Sub. Para. (2) above of Para. b above of this Sec. 2.

f. Without limiting any other terms and conditions of this Contract, Contractor's failure to comply with its obligations under Paras. a through c above under this Sec. 2 shall be a material breach of this Contract.

3. NAIC Financial Reporting

The terms and conditions of Section 3, Exhibit L in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

4. Supplemental Financial Reporting

The terms and conditions of Section 4, Exhibit L in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

5. Other Required Reports

The terms and conditions of Section 5, Exhibit L in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

6. Assumption of Risk/Private Market Reinsurance

The terms and conditions of Section 6, Exhibit L in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

7. Restricted Reserve Requirements

The terms and conditions of Section 7, Exhibit L in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

8. Risk Based Capital and Capital Adequacy Requirements

The terms and conditions of Section 8, Exhibit L in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

9. Sustainable Rate of Growth Requirement

The terms and conditions of Section 9, Exhibit L in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

10. Delivery of Reports, Information, and Documents to OHA

The terms and conditions of Section 10, Exhibit L in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

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Exhibit M – Behavioral Health

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

Behavioral Health services must be provided to improve the transition of Members from higher levels of care into integrated settings in the Community. Sufficient and appropriate Behavioral Health services must be provided to enable Members to integrate and live successfully in the Community and avoid incarceration and unnecessary hospitalization.

1. Behavioral Health Requirements

The terms and conditions of Paragraphs a – g of Section 1, Exhibit M in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

h. With respect to the provision of Behavioral Health Care services Contractor shall, as required by Enrolled Oregon House Bill 3046 (2021), provide Behavioral Health services that include but are not limited to:

(1) For a Member who is experiencing a Behavioral Health crisis, a Behavioral Health assessment and services that are Medically Necessary to transition the Member to a lower level of care;

(2) At least the minimum level of services that are Medically Necessary to treat a Member's underlying Behavioral Health condition rather than a mere amelioration of current symptoms, such as suicidal ideation or psychosis, as determined in a Behavioral Health assessment of the Member or specified in the Member's care plan;

(3) Treatment of co-occurring Behavioral Health disorders or medical conditions in a coordinated manner;

(4) Treatment at the least intensive and least restrictive level of care that is safe and effective and meets the needs of the Member's condition;

(5) For all level of care placement decisions, placement at the level of care consistent with a Member's score or assessment using the relevant level of care placement criteria and guidelines;

(a) If there is a disagreement about the level of care required by Ex. M, Sec. 1, Para h., Sub. Para. (5) or (6), Contractor shall provide to the Behavioral Health treatment Provider full details of Contractor's scoring or assessment, to the extent permitted by HIPAA and other Applicable Laws limiting the disclosure of health information.

(6) If the level of placement described in Ex. M, Sec. 1, Para. h, Sub. Para. (5) is not available, placement at the next higher level of care;

(7) Treatment to maintain functioning or prevent deterioration;

(8) Treatment for an appropriate duration based on the Member's particular needs;

(9) **[RESERVED];**

(10) Treatment appropriate to the unique needs of older adults;

(11) Treatment that is Culturally and Linguistically Appropriate;

(12) Treatment that is appropriate to the unique needs of gay, lesbian, bisexual, and transgender Members and Members of any other minoritized gender identity or sexual orientation; and

(13) Coordinated care and case management as specified in this Contract and the applicable OARs.

2. Financial Matters Relating to Behavioral Health Services

The terms and conditions of Section 2, Exhibit M in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

3. Integration, Transition, and Collaboration with Partners

The terms and conditions of Section 3, Exhibit M in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

4. Policies and Procedures

The terms and conditions of Section 4, Exhibit M in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

5. Referrals, Prior Authorizations, and Approvals

The terms and conditions of Section 5, Exhibit M in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

6. Screening Members

The terms and conditions of Section 6, Exhibit M in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

7. Substance Use Disorders

The terms and conditions of Paragraphs a – d of Section 7, Exhibit M in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

e. Ensure that specialized, Trauma Informed, SUD services are provided in environments that are Culturally and Linguistically Appropriate, designed specifically for the following groups:

(1) [RESERVED],

(2) Individuals who identify as LGBTQIA2S+,

(3) Women, and women's specific issues,

(4) Ethnically and racially diverse groups,

(5) Intravenous drug users,

(6) Individuals involved with the criminal justice system,

(7) Individuals with Co-Occurring Disorders,

(8) Parents accessing residential treatment with any accompanying dependent children,

(9) Veterans and military service members; and

(10) Individuals accessing residential treatment with Medication Assisted Treatment,

f. Provide withdrawal management services at the most Medically Appropriate level of care. Withdrawal management settings include outpatient ambulatory, residential, and inpatient. Non-Hospital based facilities or programs providing withdrawal management services at ASAM Levels 3-WM through 3.7-WM must have a license from OHA in accordance with OAR Chapter 415, Division 12 and follow the program standards specified in OAR Chapter 415, Division 50.

The terms and conditions of Paragraphs g-i of Section 7, Exhibit M in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

j. Require all staff (including staff of any Subcontractor(s)) making Prior Authorization (PA) determinations for SUD treatment services and supports have a working knowledge of the ASAM Criteria, as required by the OHP SUD 1115 Demonstration waiver. Contractor shall submit to OHA, via Administrative Notice, by July 31 of each Contract Year an Attestation of its compliance with this requirement. Contractor shall also provide to OHA, via Administrative Notice, the information that is the basis of its Attestation within five (5) Business Days of request by OHA. Such information may include but is not limited to staff training, experience, continuing education, and credentials specific to the ASAM Criteria. Consistent with Ex. B, Part 9, OHA has the right to impose one or more Sanction(s) if it determines that Contractor's Attestation is false.

8. Co-Occurring Disorders

The terms and conditions of Section 8, Exhibit M in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

9. Gambling Disorders

The terms and conditions of Section 9, Exhibit M in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

10. Assertive Community Treatment

The terms and conditions of Section 10, Exhibit M in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

11. Peer Delivered Services and Outpatient Behavioral Health Services

The terms and conditions of Section 11, Exhibit M in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

12. Behavioral Health Crisis Management System

The terms and conditions of Section 12, Exhibit M in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

13. Care Coordination

The terms and conditions of Section 13, Exhibit M in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

14. Community Partner Engagement

a. Contractor shall enter into and maintain a written agreement with the Local Mental Health Authority(ies) in Contractor's Service Area in accordance with ORS 414.153. The agreement shall include, without limitation, all of the terms and conditions set forth in ORS 414.153(4) and shall require Contractor to coordinate and collaborate on the development of Contractor's

Community Health Improvement Plan with the LMHA(s) and CMHP(s) for the delivery of mental health services in accordance with ORS 430.630.

b. Contractor shall provide OHA with an annual CBHP update and progress Report by December 31 of each Contract Year for the 12-month period ending on the immediately preceding June 30. OHA will provide a Guidance Document and reporting template for the annual CBHP update and progress Report and make them available to Contractor on the CCO Contract Forms Website.

(1) OHA's reporting template for the annual CBHP Report may require Contractor to provide data for key metrics previously submitted through the standalone Annual Behavioral Health Report that was discontinued after Contract Year four (2023). Contractor shall ensure that its Subcontractors and Participating Providers supply all required information to support the reporting described in this Sub.Para. (1).

15. Oregon State Hospital

The terms and conditions of Section 15, Exhibit M in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

16. Emergency Department Utilization

The terms and conditions of Section 16, Exhibit M in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

17. [RESERVED]

18. [RESERVED]

19. Acute Inpatient Hospital Psychiatric Care

The terms and conditions of Section 19, Exhibit M in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

20. Pregnant Individuals' Health

*The terms and conditions of Section 20, Exhibit M in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein***.**

21. Children and Youth Behavioral Health Services

a. Contractor shall provide services to children, young adults and families that are sufficient in frequency, duration, location, and type that are convenient to the youth and Family. Services should alleviate crisis while allowing for the development of natural supports, skill development, normative activities and therapeutic resolution to Behavioral Health disorders and environmental conditions that may impact the remediation of a Behavioral Health disorder.

b. Contractor shall ensure women with children, unpaid caregivers, and families receive immediate intake and assessment in accordance with timely access standards in OAR 410-141-3515.

c. Contractor shall maintain an intensive and flexible service continuum for children and youth who are at risk of placement disruption, school failure, criminal involvement, becoming Homeless or other undesirable outcomes due a Behavioral Health disorder.

d. Contractor shall utilize Evidence-Based Behavioral Health interventions for the Behavioral Health needs of Members who are children and youth.

e. [RESERVED].

f. Contractor shall ensure that children in the highest levels of care (subacute, residential or day treatment) received Family treatment with their caregivers provided that no Social Determinants of Health or other conditions will preclude such caregivers from actively and meaningfully participating in Family treatment. Contractor shall also ensure that children in the highest levels of care (subacute, residential or day treatment) have, if clinically indicated, a psychological evaluation current within the past twelve (12) months and will receive a child psychiatric evaluation and ongoing psychiatric care in accordance with OAR 309-022-0155. Should a child under age six (6) be in day treatment, subacute, or residential care settings, a developmental evaluation shall be done in addition to a psychological evaluation, if clinically indicated.

g. [RESERVED]

h. [RESERVED]

i. Contractor shall ensure that admission to PRTS is in accordance with Certificate of Need process described in OAR 410-172-0690.

j. [RESERVED]

k. [RESERVED]

l. Wraparound Supports: Contractor shall provide Wraparound supports to eligible Members in accordance with OAR 309-019-0162 and 309-019-0163, including, without limitation the requirement that ensures the ratio of Care Coordinators, Family Support Specialists, and Youth Support Specialists to families served shall not exceed a ratio of no more than 1:15.

(1) Contractor shall develop and maintain written Wraparound policies and procedures which must include, without limitation:

(a) Processes Wraparound Teams must follow when selecting services and supports and identifying those which will require the prior approval of the Providers before receiving such services and supports;

(b) Processes Wraparound Teams will be required to follow in order to obtain prior approval, from Contractor or its Subcontractor, for those services and supports that require such approval; and

(c) A plan that details how Contractor will meet the needs of children and adolescents in Contractor's Service Area who are eligible to receive Wraparound services.

(2) Contractor may contact OHA's Wraparound and System of Care Coordinator in the Child and Family Behavioral Health Unit for technical assistance with drafting its Wraparound policies and procedures.

(3) If Contractor lacks Provider capacity to provide Wraparound, Contractor shall notify OHA and develop a plan to increase Provider capacity.

(a) Lack of capacity may not be a basis to allow Members who are eligible for Wraparound supports to be placed on a waitlist.

(b) No Member on a waitlist for Wraparound may be without such services for more than fourteen (14) days.

m. OHA will provide Contractor with a document that identifies the content requirements for its Wraparound P&Ps for the then-current Contract Year. The document identifying the Wraparound P&Ps content requirements will be located on the CCO Contract Forms Website. By January 31

of each Contract Year, Contractor shall submit to OHA, via Administrative Notice, an Attestation stating that its Wraparound P&Ps meet the requirements specified in the document identifying the Wraparound P&Ps content requirements. Contractor shall provide to OHA, via Administrative Notice, the Wraparound P&Ps that are the basis of its Attestation within five (5) Business Days of request by OHA. Without limiting any other rights and remedies OHA may have under this Contractor OHA has the right, in accordance with Ex. B, Part 9, to impose one or more Sanctions if it determines that Contractor's Attestation is false.

n. Contractor shall provide Wraparound in compliance with the following:

(1) **[RESERVED]**

(2) Contractor shall convene and maintain a Wraparound Review Committee in accordance with OAR 309-019-0163.

(3) Contractor shall ensure the implementation of Fidelity Wraparound by requiring Wraparound Providers to hire and train the following staff:

(a) Wraparound Care Coordinator;

(b) Wraparound supervisor;

(c) Wraparound Coach;

(d) Youth Peer Delivered Service Provider;

(e) Family Peer Delivered Service Provider; and

(f) Peer Delivered Service Provider supervisors.

(4) Contractor shall ensure Behavioral Health Providers (including day treatment, PRTS, SAIP and SCIP Providers) are trained in Wraparound values and principles and the Provider's role within the Wraparound child and Family Team.

(5) OHA will review Contractor's Behavioral Health data and conduct Fidelity reviews in order to determine whether Contractor has complied with its Wraparound obligations under this Para. o, Sec. 19, Ex. M. Fidelity reviews will occur as follows: (i) in accordance with OAR 309-019-0163(15); (ii) in connection with receipt of Wraparound Fidelity Tool Index Tool (WFIEZ) used by OHA; (iii) once per biennium; and (iv) as may be requested from time to time by OHA. OHA shall have the right to request, and upon any such request, Contractor shall promptly provide OHA with, information and documents created as a result of the provision of Wraparound Services, including, without limitation, the documentation generated as a result of assessments conducted under OAR 309-019-0163(9)-(11) and any other information and documentation related to its compliance review. OHA shall also have the right to conduct interviews of those families enrolled in Wraparound services, Wraparound coaches, and other third parties involved in the provision and authorization of Wraparound services including, without limitation.

o. Contractor shall develop and implement Cost-Effective comprehensive, person-centered, individualized, and community-based Child and Youth Behavioral Health services for Members, using of System of Care (SOC) values.

(1) Contractor shall establish and maintain a functional System of Care in its Service Area.

(2) Contractor shall have a functional SOC governance structure.

(a) The SOC governance structure shall consist of a Practice Level Workgroup, Advisory Committee, and Executive Council with a goal of meaningful youth and family representation.

(b) As long as the functions are carried out Contractor may combine its Practice Level Workgroup with its Advisory Committee, or with its Executive Council, or with both its Advisory Committee and Executive Council,. Contractor shall work with any and all other CCOs within the same Service Area (if applicable) to ensure a singular, collaborative System of Care structure for the Service Area.

(c) The Practice Level Workgroup shall review Wraparound practice barriers, remove barriers when possible, and submit system barriers that remain unresolved to the SOC Advisory Committee and/or Executive Council for resolution and/or advancement to the State System of Care Steering Committee.

(d) The Practice Level Workgroup must consist of representatives of Providers who supervise individuals from local public child serving agencies (Child Welfare, education, juvenile justice, OYA, Tribal communities, intellectual/developmental disabilities, Behavioral Health) and must include meaningful participation from youth and Family members.

(e) The Advisory Committee shall advise on policy development, implementation, and provide oversight using a strategic plan. It shall respond to system barriers which the Practice Level Workgroup cannot resolve, making recommendations to the Executive Council as needed.

(f) The Advisory Committee must consist of representatives of Providers, local public child serving agencies (Child Welfare, education, juvenile justice, OYA, Tribal communities, intellectual/developmental disabilities, Behavioral Health) all of whom must have authority to make program level financial and policy changes, and must include meaningful participation from youth and Family members.

(g) The Executive Council shall develop and approve policies and shared decision-making regarding funding and resource development, review project outcomes, and identify unmet needs in the community to support the expansion of the service array.

(h) The Executive Council must consist of representatives of Contractor, Providers, local public child serving agencies (Child Welfare, education, juvenile justice, OYA, Tribal communities, intellectual/developmental disabilities, Behavioral Health) all of whom must have authority to make program level financial and policy changes, and must include meaningful participation from youth and Family members.

(3) Contractor shall develop SOC policies and procedures (P&P) that address the components listed below. Contractor's SOC policies and procedures shall be approved by its SOC Executive Council.

(a) How Contractor meaningfully supports the leadership and involvement of youth and families at all levels of the SOC governance structure.

(b) How Contractor supports and invests in a SOC that is both Culturally and Linguistically Appropriate to the needs of the communities in Contractor's Service Area.

(c) How Contractor supports the inclusion and collaboration of Community partners and system partners to ensure youth and families have access to necessary supports and services.

(4) OHA will provide Contractor with a document that identifies the content requirements for its SOC P&Ps for the then-current Contract Year. The document identifying the SOC P&Ps content requirements will be located on the CCO Contract Forms Website. By January 31 of each Contract Year, Contractor shall submit to OHA, via Administrative Notice, an Attestation stating that its SOC P&Ps meet the requirements specified in the document identifying the SOC P&Ps content requirements. Contractor shall provide to OHA, via Administrative Notice, the SOC P&Ps that are the basis of its Attestation within five (5) Business Days of request by OHA. Without limiting any other rights and remedies OHA may have under this Contractor OHA has the right, in accordance with Ex. B, Part 9, to impose one or more Sanctions if it determines that Contractor's Attestation is false.

(5) Contractor shall submit bi-annual reports related to barriers for the System of Care Advisory Council - State Agency Standing Committee to OHA, via Administrative Notice, within thirty (30) days after the end of each six-month period. Contractor shall use the template provided by OHA on the CCO Contract Forms Website.

p. [RESERVED]

22. Intensive In-Home Behavioral Health Treatment

a. Contractor shall provide access to Intensive In-Home Behavioral Health Treatment (IIBHT) services for all eligible Members age nineteen (19) up to their twenty-first (21st) birthdate in accordance with OARs 309-019-0167, 410-172-0650, and 410-172-0695.

(1) If Contractor lacks Provider capacity to provide IIBHT services, Contractor shall immediately notify OHA, via Administrative Notice, and develop and Submit within seven (7) Business Days, via Administrative Notice, a plan to increase Provider capacity within sixty (60) days ("60-Day Plan").

(a) Lack of capacity is not a basis for putting Members who are eligible for IIBHT on a waitlist.

(b) No Member eligible for IIBHT services may be without such services for more than fourteen (14) days.

(c) Contractor shall submit a progress report for its 60-Day Plan to OHA, via Administrative Notice, every thirty (30) days. If Contractor has not, as determined by OHA in its reasonable discretion, made sufficient progress to increase Provider capacity, OHA may, but is not required, to extend the duration of the 60-Day Plan and require Contractor to continue to submit progress reports every thirty (30) days until OHA has determined, in its reasonable discretion, that Contractor is making sustainable progress toward meeting Provider capacity. OHA reserves the right to impose one or more Sanctions as described

Ex. B, Pt. 9 if, at the conclusion of the sixty (60) days of the 60-Day Plan, Contractor continues to lack capacity to provide IIBHT services.

(2) Contractor shall maintain sufficient funding and resources to implement the IIBHT program for Members twenty (20) years and younger for any Member meeting entry criteria.

(3) Contractor shall make culturally and linguistically appropriate information about IIBHT easily available and accessible on Contractor's website where other information about Member benefits is provided. At a minimum, the IIBHT information on Contractor's website must provide a brief description of IBIHT, explain how Members can access IIBHT, and provide the contact information for Contractor's Participating Providers for IIBHT.

(4) Contractor shall submit to OHA, via Administrative Notice, quarterly reports about IIBHT referrals and enrollments with each of Contractor's Participating Providers. Each report is due within thirty (30) days after each calendar quarter. Contractor shall use the reporting template provided by OHA on the CCO Contract Forms Website.

23. Reporting Requirements

The terms and conditions of Section 23, Exhibit M in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

24. Providers

The terms and conditions of Section 24, Exhibit M in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

25. Mental Health Parity Reporting Requirements

The terms and conditions of Section 25, Exhibit M in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

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Exhibit N – Privacy and Security

The terms and conditions of Exhibit N in the Medicaid Contract are incorporated by reference and have the same force and effect as though they are fully set forth herein.

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General Provisions – Attachment 1

Permanent URLs for OARs

As described in Section 4.1.2 of the General Provisions, this Contract is structured in a manner that is substantively similar, in form and content, to the Medicaid Contract. Accordingly, in an effort to avoid unintended differences between this Contract and the Medicaid Contract, individual sections within Exhibits A through N of this Contract that are identical to the corresponding Exhibits and sections of the Medicaid Contract, are incorporated by reference as though fully set forth in such Exhibits and individual sections of this Contract. In alignment with this structure, the tables below provide the permanent URL for each OAR and OAR Chapter and Division referenced in this Contract, regardless of whether they appear in the body of this Contract or are incorporated by reference to the Medicaid Contract.

General Provisions		
OAR	**Rule Title**	**Permanent Link to OAR**
410-115-0010	Application (OHP Bridge)	*New rule effective 6/1/2024; permanent link to OAR not yet available*
410-115-0005	Acronyms and Definitions	*New rule effective 6/1/2024; permanent link to OAR not yet available*
410-115-0030	OHP Bridge Covered Services	*New rule effective 6/1/2024; permanent link to OAR not yet available*
Chapter 410, Division 115	OHP Bridge	*New rule effective 6/1/2024; permanent link to OAR not yet available*
410-141-3501	Administration of Oregon Integrated and Coordinated Health Care Delivery System Regulation; Rule Precedence	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=265501
410-200-0215	Citizenship and Non-Citizenship Status Requirements	*Rule currently open for review, updated language will be effective 6/1/2024; permanent link to OAR not yet available*

Definitions		
OAR	**Rule Title**	**Permanent Link to OAR**
137-004-0080	Reconsideration — Orders in Other than Contested Case	https://secure.sos.state.or.us/oard/view.action?ruleNumber=137-004-0080
137-004-0092	Stay Proceeding and Order — Orders in Other than Contested Case	https://secure.sos.state.or.us/oard/view.action?ruleNumber=137-004-0092
309-019-0105	Definitions (Outpatient Behavioral Health Services)	https://secure.sos.state.or.us/oard/view.action?ruleNumber=309-019-0105
309-019-0167	Intensive In-Home Behavioral Health Treatment (IIBHT) for Children	https://secure.sos.state.or.us/oard/view.action?ruleNumber=309-019-0167
309-019-0225	Assertive Community Treatment (ACT) Definitions	https://secure.sos.state.or.us/oard/view.action?ruleNumber=309-019-0225
309-022-0105	Definitions (Children & Adolescents: Intensive Treatment Services; Integrated Licenses; Children's Emergency Safety Intervention Specialists)	https://secure.sos.state.or.us/oard/view.action?ruleNumber=309-022-0105

Definitions		
OAR	**Rule Title**	**Permanent Link to OAR**
309-032-0860	Definitions (Community Treatment and Support Services)	https://secure.sos.state.or.us/oard/view.action?ruleNumber=309-032-0860
309-036-0105	Definitions (Community Mental Health Housing Fund)	https://secure.sos.state.or.us/oard/view.action?ruleNumber=309-036-0105
409-055-0040	Recognition Criteria	https://secure.sos.state.or.us/oard/view.action?ruleNumber=409-055-0040
410-115-0005	Purpose (OHP Bridges)	*New rule effective 6/1/2024; permanent link to OAR not yet available*
Chapter 410, Division 115	OHP Bridge	*New rule effective 6/1/2024; permanent link to OAR not yet available*
410-120-0000	Acronyms and Definitions (Medical Assistance Programs)	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-120-0000
410-120-1210	Medical Assistance Benefit Packages and Delivery System	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-120-1210
410-134-0003	CWM Benefit Plans and State-Funded Supplemental Wraparound Services	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-134-0003
410-141-3500	Definitions (Oregon Health Plan)	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3500
410-141-3525	Outcome and Quality Measures	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3525
410-141-3565	Managed Care Entity Billing	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3565
410-141-3566[6]	Telemedicine and Telehealth Delivered Health Service and Reimbursement Requirements	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3566
410-141-3570	Managed Care Entity Encounter Claims Data Reporting	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3570
410-141-3575	CCO Member Relations: Marketing	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3575
410-141-3700	CCO Application and Contracting Procedures	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3700
410-141-3710	Contract Termination and Close-Out Requirements	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3710
410-141-3725	CCO Contract Renewal Notification	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3725
410-141-3730	Community Health Assessment and Community Health Improvement Plans	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3730
410-141-3735	Social Determinants of Health and Equity; Health Equity	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3735

[6] The CCO-specific telehealth rule at OAR 410-141-3566 will be repealed effective 1/1/2025. It will be replaced with the FFS telehealth rule at OAR 410-141-1990, which will be revised to incorporate CCO-specific requirements.

Definitions		
OAR	**Rule Title**	**Permanent Link to OAR**
410-141-3810	Disenrollment from CCOs	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3810
410-141-3820	Covered Services	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3820
410-141-3845	Health-Related Services	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3845
410-141-3855	Pharmaceutical Services	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3855
410-141-3865	Care Coordination: Identification of Member Needs	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3865
410-141-3870	Care Coordination: Service Coordination	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3870
410-141-3875	CCO Grievances & Appeals: Definitions and General Requirements	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3875
410-141-3890	Grievances & Appeals: Appeal Process	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3890
410-141-5285	CCO Holding Company Regulation: Definitions	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-5285
410-170-0020	Definitions (Behavior Rehabilitation Services Program General Rules)	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-170-0020
Chapter 410, Division 172	Medicaid Payment for Behavioral Health Services	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1740
410-180-0305	Definitions (Traditional Health Workers)	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-180-0305
410-200-0400	Specific Requirements; Breast and Cervical Cancer Treatment Program (BCCTP)	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-200-0400
Chapter 411, Division 4	Home and Community-Based Services and Settings and Person-Centered Service Planning	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1746
461-195-0301	Definitions (Liens, Overpayments and IPVs)	https://secure.sos.state.or.us/oard/view.action?ruleNumber=461-195-0301
461-195-0303	Personal Injury Claim	https://secure.sos.state.or.us/oard/view.action?ruleNumber=461-195-0303
943-090-0010	Definitions (Cultural Competency Continuing Education for Health Care Professionals)	https://secure.sos.state.or.us/oard/view.action?ruleNumber=943-090-0010
943-120-0100	Definitions (Provider Rules)	https://secure.sos.state.or.us/oard/view.action?ruleNumber=943-120-0100
943-120-0200	Authority System Administration	https://secure.sos.state.or.us/oard/view.action?ruleNumber=943-120-0200

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

OAR	Rule Title	Permanent Link to OAR
410-141-3715	CCO Governance; Public Meetings and Transparency	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3715

Exhibit B – Statement of Work – Part 2 – Covered and Non-Covered Services		
OAR	**Rule Title**	**Permanent Link to OAR**
309-019-0155	Enhanced Care Services (ECS) and Enhanced Care Outreach Services (ECOS)	https://secure.sos.state.or.us/oard/view.action?ruleNumber=309-019-0155
333-006-0160	Health Benefit Plans Reporting Requirements	https://secure.sos.state.or.us/oard/view.action?ruleNumber=333-006-0160
410-115-0005	Acronyms and Definitions (OHP Bridge)	*New rule effective 6/1/2024; permanent link to OAR not yet available*
410-120-0000	Acronyms and Definitions (Medical Assistance Programs)	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-120-0000
410-120-1210	Medical Assistance Benefit Packages and Delivery System	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-120-1210
410-123-1220	Coverage According to the Prioritized List of Health Services	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-123-1220
410-123-1260	OHP Dental Benefits	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-123-1260
Chapter 410, Division 124	Transplant Services	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1712
410-130-0190	Tobacco Cessation	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-130-0190
410-130-0230	Administrative Medical Examinations and Reports	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-130-0230
410-130-0240	Medical Services	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-130-0240
410-130-0580	Hysterectomies and Sterilization	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-130-0580
410-130-0585	Family Planning Services	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-130-0585
Chapter 410, Division 141	Oregon Health Plan	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1728
410-141-3510	Provider Contracting and Credentialing	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3510
410-141-3515	Network Adequacy	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3515
410-141-3520	Record Keeping and Use of Health Information Technology	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3520

Exhibit B – Statement of Work – Part 2 – Covered and Non-Covered Services		
OAR	**Rule Title**	**Permanent Link to OAR**
410-141-3566[7]	Telemedicine and Telehealth Delivered Health Service and Reimbursement Requirements	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3566
410-141-3570	Managed Care Entity Encounter Claims Data Reporting	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3570
410-141-3585	CCO Member Relations: Education and Information	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3585 d
410-141-3820	Covered Services	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3820
410-141-3825	Excluded Services and Limitations	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3825
410-141-3830	Prioritized List of Health Services	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3830
410-141-3835	CCO Service Authorization	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3835
410-141-3840	Emergency and Urgent Care Services	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3840
410-141-3855	Pharmaceutical Services	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3855
410-141-3870	Care Coordination: Service Coordination	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3870
410-141-3915	Grievances & Appeals: System Recordkeeping	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3915
410-141-3920	Transportation: NEMT General Requirements	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3920
410-141-3925	Transportation: Vehicle Equipment and Driver Standards	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3925
410-141-3935	Transportation: Attendants for Child and Special Needs Transports	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3935
410-141-3940	Transportation: Secured Transports	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3940
410-141-3945	Transportation: Ground and Air Ambulance Transports	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3945
410-141-3955	Transportation: Member Service Modifications and Rights	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3955
410-141-3965	Reports and Documentation	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3965

[7] The CCO-specific telehealth rule at OAR 410-141-3566 will be repealed effective 1/1/2025. It will be replaced with the FFS telehealth rule at OAR 410-141-1990, which will be revised to incorporate CCO-specific requirements.

Exhibit B – Statement of Work – Part 2 – Covered and Non-Covered Services		
OAR	**Rule Title**	**Permanent Link to OAR**
Chapter 410, Division 151[8]	Early and Periodic Screening, Diagnostic and Treatment	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=8155
Chapter 410, Division 172	Medicaid Payment for Behavioral Health Services	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=17400
Chapter 410, Division 173	1915(i) Home and Community Based Services State Plan Option	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=5379
Chapter 411, Division 34	State Plan Personal Care Services	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1764
Chapter 943, Division 45	Office of Training, Investigations and Safety – Adult Abuse	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=4204

Exhibit B – Statement of Work – Part 3 – Patient Rights and Responsibilities, Engagement and Choice		
OAR	**Rule Title**	**Permanent Link to OAR**
Chapter 410, Division 115	OHP Bridge	*New rule effective 6/1/2024; permanent link to OAR not yet available*
410-141-3575	CCO Member Relations: Marketing	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3575
410-141-3580	CCO Member Relations: Potential Member Information	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3580
410-141-3585	CCO Member Relations: Education and Information	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3585
410-141-3590	CCO Member Relations: Member Rights and Responsibilities	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3590
410-141-3805	Mandatory CCO Enrollment Exceptions	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3805
410-141-3810	Disenrollment from CCOs	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3810
410-200-0015	General Definitions (Eligibility for Health Systems Division Medical Programs)	*Rule currently open for review, updated language will be effective 6/1/2024; permanent link to OAR not yet available*

Exhibit B – Statement of Work – Part 4 – Providers and Delivery Systems		
OAR	**Rule Title**	**Permanent Link to OAR**
409-055-0000	Purpose and Scope (Patient-Centered Primary Care Homes)	https://secure.sos.state.or.us/oard/view.action?ruleNumber=409-055-0000

[8] OHA expects to renumber the EPSDT rules in OAR Chapter 410, Division 151 during 2025.

Exhibit B – Statement of Work – Part 4 – Providers and Delivery Systems		
OAR	**Rule Title**	**Permanent Link to OAR**
409-055-0090	Reimbursement Objectives	https://secure.sos.state.or.us/oard/view.action?ruleNumber=409-055-0090
410-123-1510	Additional Dental Care Benefits for Pregnant Individuals	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-123-1510
410-141-3510	Provider Contracting and Credentialing	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3510
410-141-3515	Network Adequacy	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3515
410-141-3560	Resolving Contract Disputes Between Health Care Entities and CCOs	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3560
410-141-3565	Managed Care Entity Billing	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3565
410-141-3805	Mandatory CCO Enrollment Exceptions	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3805
410-141-3810	Disenrollment from CCOs	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3810
410-141-3850	Transition of Care	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3850
410-141-3860	Care Coordination: Administration, Systems and Infrastructure	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3860
410-141-3865	Care Coordination: Identification of Member Needs	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3865
410-141-3870	Care Coordination: Service Coordination	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3870
410-170-0090	BRS Types of Care	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-170-0090
410-180-0326	Background Check Requirements	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-180-0326

Exhibit B, Parts 5 through 7 are reserved.

Exhibit B – Statement of Work – Part 8 – Accountability and Transparency of Operations		
OAR	**Rule Title**	**Permanent Link to OAR**
409-025-0100	Definitions (All Claims All Payer Data Reporting Program)	https://secure.sos.state.or.us/oard/view.action?ruleNumber=409-025-0100
409-025-0160	Data Access and Release	https://secure.sos.state.or.us/oard/view.action?ruleNumber=409-025-0160
409-025-0170	Public Disclosure	https://secure.sos.state.or.us/oard/view.action?ruleNumber=409-025-0170
409-025-0190	Data Review Committee	https://secure.sos.state.or.us/oard/view.action?ruleNumber=409-025-0190

Exhibit B – Statement of Work – Part 8 – Accountability and Transparency of Operations		
OAR	**Rule Title**	**Permanent Link to OAR**
Chapter 409, Division 65	Sustainable Health Care Cost Growth Target Program	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=5882
409-070-0000	Scope and Purpose (Health Care Market Oversight Program)	https://secure.sos.state.or.us/oard/view.action?ruleNumber=409-070-0000
409-070-0085	Effective Date; Implementation	https://secure.sos.state.or.us/oard/view.action?ruleNumber=409-070-0085
410-120-1260	Provider Enrollment	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-120-1260
410-120-1280	Billing	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-120-1280
410-120-1295	Non-Participating Provider	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-120-1295
410-120-1300	Timely Submission of Claims	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-120-1300
410-120-1340	Payment	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-120-1340
410-120-1560	Provider Appeals	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-120-1560
Chapter 141	Oregon Health Plan	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1728
410-141-3520	Record Keeping and Use of Health Information Technology	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3520
410-141-3565	Managed Care Entity Billing	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3565
410-141-3570	Managed Care Entity Encounter Claims Data Reporting	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3570
410-141-3810	Disenrollment from CCOs	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3810
410-141-3840	Emergency and Urgent Care Services	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3840
410-141-5320	CCO Holding Company Regulation: Transactions Within Holding Company	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-5320
410-141-5325	CCO Holding Company Regulation: Director and Officer Liability; Effect of Control of CCO Subject to Registration; Board of Directors	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-5325
410-141-5310	CCO Holding Company Regulation: Presumption of Control; Rebuttal	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-5310
410-141-5315	CCO Holding Company Regulation: Disclaimer of Affiliation	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-5315

Exhibit B – Statement of Work – Part 8 – Accountability and Transparency of Operations		
OAR	**Rule Title**	**Permanent Link to OAR**
461-195-0301	Definitions (Liens, Overpayments and IPVs)	https://secure.sos.state.or.us/oard/view.action?ruleNumber=461-195-0301
461-195-0303	Personal Injury Claim	https://secure.sos.state.or.us/oard/view.action?ruleNumber=461-195-0303
461-195-0305	Lien of the Department, Coordinated Care Organization, or Prepaid Managed Care Health Services Organization	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=249034
461-195-0310	Notice of Claim or Action by Applicant or Recipient	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=299870
461-195-0320	Release of Lien for Future Medicals	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=130971
461-195-0321	Assigning a Lien	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=130973
461-195-0325	Release or Compromise of Lien	https://secure.sos.state.or.us/oard/view.action?ruleNumber=461-195-0325
461-195-0350	Procedure Where Injured Recipient is a Minor	https://secure.sos.state.or.us/oard/view.action?ruleNumber=461-195-0350
943-014-0010	Purpose (Privacy and Confidentiality)	https://secure.sos.state.or.us/oard/view.action?ruleNumber=943-014-0010
943-014-0300	Scope (Privacy and Confidentiality)	https://secure.sos.state.or.us/oard/view.action?ruleNumber=943-014-0300
943-014-0320	User Responsibility	https://secure.sos.state.or.us/oard/view.action?ruleNumber=943-014-0320
943-120-0100	Definitions (Provider Rules)	https://secure.sos.state.or.us/oard/view.action?ruleNumber=943-120-0100
943-120-0200	Authority System Administration	https://secure.sos.state.or.us/oard/view.action?ruleNumber=943-120-0200

Exhibit B – Statement of Work – Part 9 – Program Integrity		
OAR	**Rule Title**	**Permanent Link to OAR**
410-120-1396	Provider and Contractor Audits	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-120-1396
410-120-1510	Fraud and Abuse	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-120-1510
410-120-1580	Provider Appeals — Administrative Review	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-120-1580
410-141-3520	Record Keeping and Use of Health Information Technology	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3520
410-141-3530	Sanctions	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3530
410-141-3531	Sanctions for Failure to Comply with State or Federal Information Security or Privacy Laws	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3531

Exhibit B – Statement of Work – Part 9 – Program Integrity		
OAR	**Rule Title**	**Permanent Link to OAR**
410-141-3570	Managed Care Entity Encounter Claims Data Reporting	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3570
410-141-3625	CCO Assessment: Authority to Audit Records	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3625
410-141-3835	CCO Service Authorization	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3835

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

Exhibit C – Consideration		
OAR	**Rule Title**	**Permanent Link to OAR**
309-019-0105	Definitions (Outpatient Behavioral Health Services)	https://secure.sos.state.or.us/oard/view.action?ruleNumber=309-019-0105
309-019-0145	Co-Occurring Mental Health and Substance Use Disorders (COD)	https://secure.sos.state.or.us/oard/view.action?ruleNumber=309-019-0145
Chapter 309, Division 65	Culturally and Linguistically Specific Services	*New rule effective 1/1/2023; permanent link to OAR not yet available*
Chapter 410, Division 120	Medical Assistance Programs	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1708
410-120-1580	Provider Appeals — Administrative Review	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=83200
410-130-0580	Hysterectomies and Sterilization	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-130-0580
410-141-3565	Managed Care Entity Billing	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3565

Exhibit D – Standard Terms and Conditions		
OAR	**Rule Title**	**Permanent Link to OAR**
Chapter 309, Division 12	Administrative Practice and Procedure	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1009
Chapter 309, Division 14	Community Mental Health Programs	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1011
Chapter 309, Division 15	Medicaid Payment for Inpatient Psychiatric Hospital Inpatient Services	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1012
Chapter 309, Division 18	Residential Substance Use Disorders and Problem Gambling Treatment and Recovery Services	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1015

Exhibit D – Standard Terms and Conditions		
OAR	**Rule Title**	**Permanent Link to OAR**
Chapter 309, Division 19	Outpatient Behavioral Health Services	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1016
Chapter 309, Division 22	Children & Adolescents: Intensive Treatment Services; Integrated Licenses; Children's Emergency Safety Intervention Specialists	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1019
Chapter 309, Division 32	Community Treatment and Support Services	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1026
Chapter 309, Division 40	Adult Foster Homes	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1034
Chapter 407, Division 46	Office of Training, Investigations and Safety – Child-In-Care Abuse	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=6493
Chapter 407, Division 47	Office of Training, Investigations and Safety – Child Abuse	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=5419
Chapter 410	Health Systems Division: Medical Assistance Programs	https://secure.sos.state.or.us/oard/displayChapterRules.action
Chapter 410, Division 115	OHP Bridge	*New rule effective 6/1/2024; permanent link to OAR not yet available*
410-120-1560	Provider Appeals	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-120-1560
410-120-1580	Provider Appeals — Administrative Review	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-120-1580
Chapter 410, Division 141	Oregon Health Plan	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1728
Chapter 415	Health Systems Division: Addiction Services	https://secure.sos.state.or.us/oard/displayChapterRules.action
410-141-3710	Contract Termination and Close-Out Requirements	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3710
410-141-5080	Financial Solvency Regulation: Transparency	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-5080
Chapter 407, Division 45	Office of Training, Investigations and Safety – Adult Abuse	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1635

Exhibit E – Required Federal Terms and Conditions		
OAR	**Rule Title**	**Permanent Link to OAR**
199-005-0001	Definitions (Gifts)	https://secure.sos.state.or.us/oard/view.action?ruleNumber=199-005-0001

Exhibit E – Required Federal Terms and Conditions		
OAR	**Rule Title**	**Permanent Link to OAR**
199-005-0030	Determining the Source of Gifts	https://secure.sos.state.or.us/oard/view.action?ruleNumber=199-005-0030
Chapter 407, Division 14	Privacy and Confidentiality	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1629
410-120-1380	Compliance with Federal and State Statutes	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-120-1380
Chapter 943, Division 14	Privacy and Confidentiality	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=4203
943-120-0100	Definitions (Provider Rules)	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=229991
943-120-0110	Purpose	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=229995
943-120-0112	Scope and Sequence of Electronic Data Transmission Rules	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=229999
943-120-0114	Provider Enrollment Agreement	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=230003
943-120-0116	Web Portal Submitter	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=230007
943-120-0118	Conduct of Direct Data Entry Using Web Portal	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=230011
943-120-0120	Registration Process — EDI Transactions	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=230015
943-120-0130	Trading Partner as EDI Submitter — EDI Transactions	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=230019
943-120-0140	Trading Partner Agents as EDI Submitters — EDI Transactions	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=230021
943-120-0150	Testing — EDI Transactions	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=230023
943-120-0160	Conduct of Transactions — EDI Transactions	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=230025
943-120-0165	Pharmacy Point of Sale Access	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=230027
943-120-0170	Security	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=230029
943-120-0180	Record Retention and Audit	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=230033
943-120-190	Material Changes	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=230037
943-120-0200	Authority System Administration	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=230039

Exhibit F – Insurance Requirements		
OAR	**Rule Title**	**Permanent Link to OAR**
None		

Exhibit G – Reporting of Delivery System Network Providers, Cooperative Agreements, and Hospital Adequacy		
OAR	**Rule Title**	**Permanent Link to OAR**
410-141-3515	Network Adequacy	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3515

Exhibit H – Value Based Payment is reserved.

Exhibit I – Grievance and Appeal System		
OAR	**Rule Title**	**Permanent Link to OAR**
410-120-1860	Contested Case Hearing Procedures	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-120-1860
410-141-3585	CCO Member Relations: Education and Information	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3585 d
410-141-3835	CCO Service Authorization	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3835
410-141-3850	Transition of Care	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3850
410-141-3875	CCO Grievances & Appeals: Definitions and General Requirements	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3875
410-141-3880	Grievances & Appeals: Grievance Process Requirements	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3880
410-141-3885	Grievances & Appeals: Notice of Action/Adverse Benefit Determination	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3885
410-141-3890	Grievances & Appeals: Appeal Process	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3890
410-141-3895	Grievances & Appeals: Expedited Appeal	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3895
410-141-3900	Grievances & Appeals: Contested Case Hearings	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3900
410-141-3905	Grievances & Appeals: Expedited Contested Case Hearings	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3905
410-141-3910	Grievances & Appeals: Continuation of Benefits	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3910
410-141-3915	Grievances & Appeals: System Recordkeeping	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3915
410-141-3920	Transportation: NEMT General Requirements	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3920

Exhibit J – Health Information Technology

OAR	Rule Title	Permanent Link to OAR
410-120-1280	Billing	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-120-1280
410-141-3520	Record Keeping and Use of Health Information Technology	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3520
410-141-3565	Managed Care Entity Billing	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3565
410-141-3570	Managed Care Entity Encounter Claims Data Reporting	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3570
410-141-3591	CCO Interoperability Requirements	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3591
Chapter 943, Division 120	Provider Rules	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=4208

Exhibit K – Social Determinants of Health and Equity		
OAR	**Rule Title**	**Permanent Link to OAR**
410-141-3500	Definitions (Oregon Health Plan)	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3500
410-141-3730	Community Health Assessment and Community Health Improvement Plans	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3730
410-141-3735	Social Determinants of Health and Equity; Health Equity	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3735
410-141-3845	Health-Related Services	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3845
410-141-5000	Financial Solvency Regulation: Definitions	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-5000

Exhibit L – Solvency Plan, Financial Reporting, and Sustainable Rate of Growth		
OAR	**Rule Title**	**Permanent Link to OAR**
410-141-5000	Financial Solvency Regulation: Definitions	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-5000
410-141-5005	Financial Solvency Regulation: CCO Financial Solvency Requirement	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-5005
410-141-5010	Financial Solvency Regulation: Procedure for General Financial Reporting and for Determining Financial Solvency Matters	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-5010
410-141-5015	Financial Solvency Regulation: Financial Statement Reporting	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-5015
410-141-5020	Financial Solvency Regulation: Annual Audited Financial Statements and Auditor's Report	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-5020
410-141-5045	Financial Solvency Regulation: Corporate Governance Annual Disclosure Filing	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-5045

Exhibit L – Solvency Plan, Financial Reporting, and Sustainable Rate of Growth		
OAR	**Rule Title**	**Permanent Link to OAR**
410-141-5050	Financial Solvency Regulation: Requirements for Reinsurance	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-5050
410-141-5055	Financial Solvency Regulation: Requirements for Obtaining Credit for Reinsurance	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-5055
410-141-5075	Financial Solvency Regulation: Disallowance of Certain Reinsurance Transactions	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-5075
410-141-5170	Capitalization: Capital and Surplus	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-5170
410-141-5180	Capitalization: Dividend and Distribution Restrictions	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-5180
410-141-5185	Capitalization: Restricted Reserve Account	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-5185
410-141-5195	Capitalization: Risk-based Capital (RBC) Definitions	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-5195
410-141-5200	Capitalization: RBC Reports	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-5200
410-141-5205	Capitalization: Company Action Level Event	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-5205
410-141-5220	Capitalization: Mandatory Control Level Event	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-5220
410-141-5225	Reporting and Approval of Certain Transactions: Extraordinary Dividends and Other Distributions	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-5225
410-141-5240	Reporting and Approval of Certain Transactions: Materiality and Reporting Standards for Changes in Ceded Reinsurance Agreements	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-5240
410-141-5245	Examinations: CCO Production of Books and Records	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-5245
410-141-5250	Examinations: Authority Examinations of CCOs	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-5250
410-141-5300	CCO Holding Company Regulation: Registration Statement Filing	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-5300
410-141-5320	CCO Holding Company Regulation: Transactions Within Holding Company	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-5320
410-141-5330	CCO Holding Company Regulation: Annual Enterprise Risk Report	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-5330
410-141-5380	Civil Penalties	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-5380

Exhibit M – Behavioral Health		
OAR	**Rule Title**	**Permanent Link to OAR**
Chapter 309, Division 18	Residential Substance Use Disorders and Problem Gambling Treatment and Recovery Services	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1015
Chapter 309, Division 19	Outpatient Behavioral Health Services	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1016
Chapter 309, Division 022	Children & Adolescents: Intensive Treatment Services; Integrated Licenses; Children's Emergency Safety Intervention Specialists	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1019
Chapter 309, Division 072	Mobile Crisis Intervention Services and Stabilization Services	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=7546
309-019-0105	Definitions (Outpatient Behavioral Health Services)	https://secure.sos.state.or.us/oard/view.action?ruleNumber=309-019-0105
309-019-0135	Entry and Assessment	https://secure.sos.state.or.us/oard/view.action?ruleNumber=309-019-0135
309-019-0162	Youth Wraparound Definitions	https://secure.sos.state.or.us/oard/view.action?ruleNumber=309-019-0162
309-019-0163	Youth Wraparound Program Rules	https://secure.sos.state.or.us/oard/view.action?ruleNumber=309-019-0163
309-019-0167	Intensive In-Home Behavioral Health Treatment (IIBHT) for Children	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=284989
309-019-0225	Assertive Community Treatment (ACT) Definitions	https://secure.sos.state.or.us/oard/view.action?ruleNumber=309-019-0225
309-019-0226	Assertive Community Treatment (ACT) Overview	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=309398
309-019-0230	ACT Provider Qualifications	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=309399
309-019-0233	ACT Program Certification	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=309400
309-019-0235	ACT Fidelity Requirements	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=309401
309-019-0240	ACT Failure to Meet Fidelity Standards	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=309402
309-019-0241	Waiver of Minimum Fidelity Requirements	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=309403
309-019-0242	ACT Program Operational Standards	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=309404
309-019-0245	ACT Admission Criteria	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=309406
309-019-0248	ACT Admission Process	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=309407

Exhibit M – Behavioral Health		
OAR	**Rule Title**	**Permanent Link to OAR**
309-019-0250	ACT Transition to Less Intensive Services and Discharge	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=309408
309-019-0255	ACT Reporting Requirements	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=309409
309-019-0275	Individual Placement and Support (IPS) Supported Employment Overview	https://secure.sos.state.or.us/oard/view.action?ruleNumber=309-019-0275
309-019-0280	IPS Program Requirements and Operational Standards	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=310408
309-019-0282	IPS Program Certification	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=310409
309-019-0285	IPS Fidelity Requirements	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=310410
309-019-0290	Failure to Meet Fidelity Standards	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=310411
309-019-0295	Reporting Requirements	https://secure.sos.state.or.us/oard/view.action?ruleNumber=309-019-0295
309-019-0300	Service Requirements	https://secure.sos.state.or.us/oard/view.action?ruleNumber=309-019-0300
309-019-0320	Documentation Requirements	https://secure.sos.state.or.us/oard/view.action?ruleNumber=309-019-0320
Chapter 309, Division 22	Children & Adolescents: Intensive Treatment Services; Integrated Licenses; Children's Emergency Safety Intervention Specialists	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1019
309-022-0155	General Staffing Requirements	https://secure.sos.state.or.us/oard/view.action?ruleNumber=309-022-0155
309-032-0850	Purpose (Community Treatment and Support Services)	https://secure.sos.state.or.us/oard/view.action?ruleNumber=309-032-0850
309-032-0870	Standards for Approval of Regional Acute Care Psychiatric Service	https://secure.sos.state.or.us/oard/view.action?ruleNumber=309-032-0870
309-033-0200	Statement of Purpose and Statutory Authority (Involuntary Commitment Proceedings)	https://secure.sos.state.or.us/oard/view.action?ruleNumber=309-033-0200
309-033-0210	Definitions (Civil Commitment Proceedings)	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=299354
309-033-0220	General Standards	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=299361
309-033-0225	Variances	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=299362
309-033-0230	Custody of Persons Alleged to Have a Mental Illness Prior to Filing a Notification of Mental Illness.	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=299370
309-033-0240	Initiation of the Civil Commitment Process	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=308854

Exhibit M – Behavioral Health		
OAR	**Rule Title**	**Permanent Link to OAR**
309-033-0250	Standards for Custody, Hospital and Nonhospital Holds, Emergency Commitment and Emergency Hospitalization of Persons Under Warrant of Detention	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=299372
309-033-0260	Diversion from Commitment Hearing	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=299373
309-033-0270	Provision of Care, Custody and Treatment of Persons under Civil Commitment	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=299374
309-033-0280	Procedures for Persons under Civil Commitment and on Outpatient Commitment or Trial Visit	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=299375
309-033-0290	Placement of Persons under Civil Commitment	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=299376
309-033-0300	Transfers Between Classes of Facilities	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=299377
309-033-0310	Recertification for Continued Civil Commitment	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=299378
309-033-0320	Revocation of Conditional Release, Outpatient Commitment or Trial Visit	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=299379
309-033-0330	Discharge of Civil Commitment for Persons under Civil Commitment and Placed in the Community	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=299380
309-033-0400	Statement of Purpose and Statutory Authority	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=299381
309-033-0420	Transportation and Transfer of Persons in Custody or On Diversion	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=299382
309-033-0425	Provider Requirements for the Transportation and Transfer of Minors in Custody or by Consent of Legal Guardian	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=297759
309-033-0430	Transportation of a Person under Civil Commitment to a State Hospital, Community Hospital or Nonhospital Facility	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=299383
309-033-0432	Standards for the Approval of a Secure Transport Provider to Transport a Person in Custody or On Diversion to an Approved Holding Hospital or Nonhospital Facility	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=297652
309-033-0435	Client Rights with Regards to a Secure Transport Provider	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=297653
309-033-0437	Mechanical Restraint by a Secure Transport Provider	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=297655
309-033-0500	Statement of Purpose and Statutory Authority	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=44888

Exhibit M – Behavioral Health		
OAR	**Rule Title**	**Permanent Link to OAR**
309-033-0520	Classes of Facility that Provide Care, Custody or Treatment to Persons under Civil Commitment or to Persons in Custody or on Diversion.	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=299384
309-033-0530	Approval of Hospitals and Nonhospital Facilities to Provide Services to Persons under Civil Commitment and to Persons in Custody and on Diversion.	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=299385
309-033-0540	Administrative Requirements for Hospitals and Nonhospital Facilities Approved to Provide Services to Persons in Custody.	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=299386
309-033-0550	Standards for the Approval of Hospitals Detaining Persons in Custody Pending Transport to an Approved Holding Hospital or Nonhospital Facility	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=299387
309-033-0600	Statement of Purpose and Statutory Authority	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=299389
309-033-0620	Obtaining Informed Consent to Treatment from a Person and the Administration of Significant Procedures Without the Informed Consent of a Person under Civil Commitment.	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=299390
309-033-0625	Administration of Medication and Treatment without the Informed Consent of a Person in Custody	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=299391
309-033-0630	Administration of Significant Procedures in Emergencies Without the Informed Consent of a Person under Civil Commitment	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=299392
309-033-0640	Involuntary Administration of Significant Procedures to a Committed Person With Good Cause	https://secure.sos.state.or.us/oard/view.action?ruleNumber=309-033-0640
309-033-0700	Purpose and Scope	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=299394
309-033-0720	Application, Training and Minimum Staffing Requirements	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=299395
309-033-0725	Medical Services	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=299396
309-033-0727	Structural and Physical Requirements	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=299397
309-033-0730	Seclusion and Restraint Procedures	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=299398
309-033-0732	Time Limits	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=299399

Exhibit M – Behavioral Health		
OAR	**Rule Title**	**Permanent Link to OAR**
309-033-0733	Documentation	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=299400
309-033-0735	Quarterly Reports	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=44920
309-033-0740	Variances	https://secure.sos.state.or.us/oard/view.action?ruleNumber=309-033-0740
309-091-0000	Purpose and Scope (State Hospital Admissions and Discharges)	https://secure.sos.state.or.us/oard/view.action?ruleNumber=309-091-0000
309-091-0015	Determining Need for State Hospital Care	https://secure.sos.state.or.us/oard/view.action?ruleNumber=309-091-0015
309-091-0050	Other Forensic Discharges	https://secure.sos.state.or.us/oard/view.action?ruleNumber=309-091-0050
410-141-3515	Network Adequacy	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3515
410-141-3585	CCO Member Relations: Education and Information	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3585 d
410-141-3835	CCO Service Authorization	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3835
410-141-3840	Emergency and Urgent Care Services	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3840
410-141-3860	Care Coordination: Administration, Systems and Infrastructure	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3860
410-141-3870	Care Coordination: Service Coordination	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3870
410-172-0650	Prior Authorization	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=291157
410-172-0690	Admission Procedure for Psychiatric Residential Treatment Services for Children	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-172-0690
410-172-0695	Intensive In-Home Behavioral Health Treatment Services for Youth (IIHBT)	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=291158
Chapter 415, Division 12	Licensure of Substance Use Disorders and Problem Gambling Residential Treatment and Recovery Services	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1922
Chapter 415, Division 20	Standards for Outpatient Opioid Treatment Programs	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1923
Chapter 415, Division 50	Standards for Alcohol Detoxification Centers	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1924

Exhibit N – Privacy and Security		
OAR	**Rule Title**	**Permanent Link to OAR**

Chapter 407, Division 14	Privacy and Confidentiality	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1629
410-141-3530	Sanctions	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3530
410-141-3531	Sanctions for Failure to Comply with State or Federal Information Security or Privacy Laws	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3531
Chapter 943, Division 14	Privacy and Confidentiality	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=4203

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Exhibit C – Attachment 1

CCO Payment Rates

Exhibit D – Attachment 1

Deliverables and Required Notices

[Pursuant to Section 4.3.5.1 in General Provisions, this Exhibit D-Attachment 1 only identifies those Reports where Contractor's obligation is not the same as for the Medicaid Contract. Contractor shall rely on Exhibit D-Attachment 1 provided with Contractor's Medicaid Contract for all other Reports.]