

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

APPLICANT MAY PROPOSE LANGUAGE FOR PART 1; SEE APPENDIX G

DRAFT

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

1. Covered Services

Contractor shall provide and pay for coordinated care services that are covered health services listed in this Exhibit B, in exchange for a CCO Payment based on its Global Budget.

Coordinated care services include the provision of Flexible Services and Supports that are consistent with achieving wellness and the objectives of an individualized care plan. A Flexible Service or Support must be ordered by and under the supervision of a Patient Centered Primary Care Home (PCPCH) or other primary care provider in the Contractor's Delivery System Network when authorized in accordance with CCO policy for authorizing Flexible Services or Supports.

- a.** Health services that are not Covered Services are authorized and paid outside of this Contract according to procedures provided in the General Rules and OHA Provider rules, or by separate Contract, and are not included in the Global Budget. This includes services for:
- (1) Physician assisted suicide under the Oregon Death with Dignity Act, ORS 127.800-127.897;
 - (2) Therapeutic abortions;
 - (3) Non-emergency medical transportation, which is transportation other than those classified as ambulance service(s);
 - (4) Residential Chemical Dependency Services; however, CCO must have contracts for residential chemical dependency services in effect not later than July 1, 2013.
 - (5) Dental services that are Covered Services under the dental care organization contract; however, on or before July 1, 2014, Contractor must have a formal contractual relationship with any dental care organization that serves Members in the area where they reside.
 - (6) 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;
 - (7) Hospice services for Members who reside in a skilled nursing facility.
 - (8) Long-term psychiatric care at the Oregon State Hospital, Secure Children's Inpatient Program and Secure Adolescent Inpatient Program.
 - (9) Long-term care services reimbursed under contract between LTC providers and the Department of Human Services
- b.** Contractor should inform OHA in advance of the effective date of its contracts for residential chemical dependency services or dental services under a DCO contract, to allow sufficient time to amend the contract if needed.

2. OHP Plus and OHP Standard Benefit Packages of Covered Services

- a. Subject to the provisions of this Contract, Contractor shall provide for Covered Services to Members eligible for the OHP Plus Benefit Package and the OHP Standard Benefit Package.
 - (1) Contractor shall provide the OHP Plus Benefit Package of Covered Services, OAR 410-141-2480 and OAR 410-120-1210 including diagnostic services that are necessary and reasonable to diagnose the presenting condition, regardless of whether or not the final diagnosis is covered.
 - (2) Contractor shall provide treatment, including ancillary services, which is included in or supports the Condition/Treatment Pairs that are above the funding line on the Prioritized List of Health Services, OAR 410-141-2520.
 - (3) Except as otherwise provided in OAR 410-141-2480(7), Contractor is not responsible for excluded or limited services as defined in OAR 410-141-2500.
 - (4) Before denying treatment for a condition that is below the funding line on the Prioritized List for any Member, especially a Member with a disability or co-morbid condition, Contractor shall determine whether the Member has a funded condition and paired treatment that would entitle the Member to treatment under OAR 410-141-2480.
 - (5) Contractor shall notify OHA's Transplant Coordinator of all transplant prior authorizations. Contractor must use the same limits and criteria for transplants as those established in the Transplant Services Rules, OAR 410-124-0000 et seq.
 - (6) Contractor shall provide the Limited Hospital Benefit to Members who are eligible for the OHP Standard Benefit Package who receive services in an ambulatory surgery center (ASC), as specified in OAR 410-125-0047.
- b. Subject to the provisions of this Contract, Contractor is responsible for coordinated care services for Full Dually Eligibles for Medicare and Medicaid. Contractor shall pay for covered services for Members who are Full Dually Eligible in accordance with applicable contractual requirements that include CMS and OHA.

3. Provision of Covered Service

- a. Contractor may not arbitrarily deny or reduce the amount, duration, or scope of a Covered Service solely because of the diagnosis, type of illness, or condition, subject to the Prioritized List of Health Services.
- b. Contractor shall provide to Members, at a minimum, those Covered Services that are Medically Appropriate and as described as funded condition-treatment pairs on the Prioritized List of Health Services contained in OAR 410-141-2520 and as identified, defined and specified in the OHP Administrative Rules.
- c. Contractor shall ensure all Medically Appropriate Covered Services are furnished in an amount, duration and scope that is no less than the amount, duration and scope for the same services furnished to OHP Clients under fee-for-service and as set forth in 42 CFR 438.210. Contractor also shall ensure that the Covered Services are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished and include the following:
 - (1) The prevention, diagnosis, and treatment of health impairments;

- (2) The ability to achieve age-appropriate growth and development;
- (3) The ability to attain, maintain or regain functional capacity.
- d. Contractor shall establish written utilization management policies, procedures and criteria for Covered Services. These utilization management procedures must be consistent with appropriate utilization control requirements of 42 CFR Part 456.
- e. Contractor's utilization management policies may not structured so as to provide incentives for its Provider Network to inappropriately deny, limit or discontinue Medically Appropriate services to any Member.

4. Authorization or Denial of Covered Services

- a. Contractor shall establish written procedures that Contractor follows, and requires Participating Providers to follow, for the initial and continuing authorizations of services. That procedure must require that any decision to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested, be made by a Health Care Professional who has appropriate clinical expertise in treating the Member's health or mental health condition or disease in accordance with 42 CFR 438.210.
- b. Contractor may require Members and Subcontractors to obtain authorization for Covered Services from Contractor, except to the extent prior authorization is not required in OAR 410-141-2420 or elsewhere in this Statement of Work.
- c. Contractor shall have in effect mechanisms to ensure consistent application of review criteria for authorization decisions, taking into account applicable clinical practice guidelines, and consults with the requesting Provider when appropriate.
- d. For standard service authorization requests, Contractor shall provide notice as expeditiously as the Member's health or mental health condition requires, not to exceed 14 calendar days following receipt of the request for service, with a possible extension of 14 additional calendar days if the Member or Provider requests extension, or if the Contractor justifies a need for additional information and how the extension is in the Member's interest. If Contractor extends the time frame, Contractor shall provide the Member and Provider with a written notice of the reason for the decision to extend the timeframe and inform the Member of the right to file a Grievance if he or she disagrees with that decision. When a decision is not reached regarding a service authorization request within the timeframes specified above, Contractor shall issue a notice of action to the Provider and Member, or Member Representative, consistent with Exhibit I, Grievance System.
- e. If a Member or Provider requests, or Contractor determines, that following the standard timeframes could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function, Contractor shall make an expedited service authorization decision and provide Notice as expeditiously as the Member's mental health condition requires and no later than three working days after receipt of the request for service. Contractor may extend the three working day time period by up to 14 calendar days if the Member requests an extension, or if Contractor justifies a need for additional information and how the extension is in the Member's interest.

- f.** Contractor may not restrict coverage for any hospital length of stay following a normal vaginal birth to less than 48 hours, or less than 96 hours for a cesarean section. An exception to the minimum length of stay may be made by the physician in consultation with the mother, which must be documented in the clinical record.
- g.** Contractor shall ensure the provision of sexual abuse exams without prior authorization.
- h.** Contractor shall coordinate preauthorization and related services with dental care organizations to ensure the provision of dental care with mutual Members that must be performed in an outpatient hospital or ambulatory surgical setting due to the age, disability, or medical condition of the Member.
- i.** Except as provided in Subsection h of this section, Contractor may not prohibit or otherwise limit or restrict Health Care Professionals who are its employees or Subcontractors acting within the lawful scope of practice, from advising or advocating on behalf of a Member, who is a patient of the professional, for the following:

 - (1)** For the Member’s health status, medical care, or treatment options, including any alternative treatment that may be self-administered, that is Medically Appropriate even if such care or treatment is not covered under this Contract or is subject to co-payment;
 - (2)** Any information the Member needs in order to decide among relevant treatment options;
 - (3)** The risks, benefits, and consequences of treatment or non-treatment; and
 - (4)** The Member’s right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.
- j.** Contractor is not required to provide, reimburse for, or provide coverage of a counseling or referral service, if Contractor objects to the service on moral or religious grounds. If Contractor elects not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds under this paragraph, Contractor shall adopt a written policy consistent with the provisions of 42 CFR 438.10 for such election and furnish information about the services Contractor does not cover as follows:

 - (1)** To OHA:

 - (a)** With Contractor’s application for CCO certification; and
 - (b)** Whenever Contractor adopts the policy during the term of this Contract, at least 30 days prior to Contractor’s formal adoption of the policy; and
 - (2)** Following certification, subject to OHA prior approval, to:

 - (a)** Potential Members before and during Enrollment; and
 - (b)** Members within 90 days after adopting the policy with respect to any particular service.
- k.** Contractor shall notify the requesting Provider, in writing or orally, when Contractor denies a request to authorize a Covered Service or when the authorization is in an amount, duration, or scope that is less than requested.

- l.** Contractor shall notify the Member in writing of any decision to deny a service authorization request, or to authorize a service in an amount, duration or scope that is less than requested pursuant to the requirements of Exhibit I.

5. Services Coordination for Non-covered Health Services

- a.** Contractor shall coordinate services for each Member who requires health services not covered under the Global Budget. Contractor shall arrange, coordinate, and monitor health services that are not covered within the member's benefit package on an ongoing basis.
- b.** Contractor shall assist its Members in gaining access to certain chemical dependency and mental health services that are not Covered Services and that are provided under separate contract with OHA. Services that are not Covered Services include, but are not limited to, the following:
 - (1)** Medical Transportation pursuant to rules (OAR 410-136-0020 et. seq.) promulgated by OHA and published in its Medical Transportation Services Guide;
 - (2)** 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;
 - (3)** Therapeutic Foster Care reimbursed under HCPCs Code S5145 for Members under 21 years of age;
 - (4)** Therapeutic group home reimbursed for Members under 21 years of age;
 - (5)** Behavioral rehabilitative services that are financed through Medicaid and regulated by DHS Services to Children and Families and OYA;
 - (6)** Investigation of Members for Civil Commitment;
 - (7)** Long Term Psychiatric Care (LTPC) as defined for Members 18 years of age and older;
 - (8)** Preadmission Screening and Resident Review (PASRR) for Members seeking admission to a LTPC;
 - (9)** LTPC for Members age 17 and under;
 - (a)** Secure Children's Inpatient program (SCIP)
 - (b)** Secure Adolescent Inpatient Program (SAIP)
 - (c)** Stabilization and transition services (STS)
 - (10)** Personal care in adult foster homes for Members 21 years of age and older;
 - (11)** Residential mental health services for Members 21 years of age and older provided in licensed community treatment programs;

- (12) Residential chemical dependency services provided in OHA approved community treatment programs however, CCO must have contracts for residential chemical dependency services in effect not later than July 1, 2013;
 - (13) Services provided to persons while in the legal custody of a correctional facility or jail;
 - (14) Abuse investigations and protective services as described in OAR 943-045-0250 through 943-045-0370 and ORS 430.735 through 430.765; and
 - (15) Personal Care Services as described in OAR 411-034-0000 through 411-034-0090 and OAR 309-040-0300 through 309-040-0330.
- c. Contractor may not require Members to obtain the approval of a Primary Care Physician in order to gain access to mental health or alcohol and drug Assessment and Evaluation services. Members may refer themselves to mental health services.

6. Covered Service Components

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

a. Emergency and Urgent Care Services

- (1) Contractor shall establish written policies and procedures and monitoring systems that provide for Emergency Services including post-stabilization care services, and Urgent Services for all Members on a 24-hour, 7-day-a-week basis consistent with OAR 410-141-3140 and 42 CFR 438.114.

Contractor's policies and procedures shall include an emergency response system that provides an immediate, initial and/or limited duration response for potential mental health emergency situations or emergency situations that may include mental health conditions, which consist of: screening to determine the nature of the situation and the person's immediate need for Covered Services; capacity to conduct the elements of a mental health Assessment that are needed to determine the interventions necessary to begin stabilizing the crisis situation; development of a written initial services plan at the conclusion of the mental health Assessment; provision of Covered Services and Outreach needed to address the Urgent or Emergency Situation; and linkage with the public sector crisis services, such as pre-commitment.

- (2) Contractor may not require prior authorization for Emergency Services. Contractor provides an after-hours call-in system adequate to triage Urgent Care and Emergency Service calls, consistent with OAR 410-141-3140.
- (3) Contractor shall cover and pay for Emergency Services as provided for in OAR 410-141-3140. Contractor shall cover and pay for post-stabilization services as provided for in OAR 410-141-3140 and 42 CFR 438.114.

b. Emergency Ambulance Transportation

- (1) Contractor shall pay for emergency ambulance transportation for Members including ambulance services dispatched through 911, in accordance with the Emergency Services

prudent layperson standard described in Exhibit A, definitions for “Emergency Services” and “Emergency Medical Condition”. Contractor shall make coverage decisions for emergency ambulance services based on the actual services provided.

- (2) Unless Contractor has authorized non-emergency medical transportation, Contractor is not responsible for non-emergency medical transportation. Payment for non-emergency medical transportation that has not been prior authorized by Contractor is governed by the Medical Transportation Services rules, OAR 410-136-0030 through OAR 410-136-0860. Contractor should coordinate with the member’s transportation needs when arranging for provision of coordinated care services.

c. Family Planning Services

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

d. Sterilizations and Hysterectomies

- (1) Sterilizations and Hysterectomies are a Covered Service only when they meet the federally mandated criteria 42 CFR 441.250 to 441.259 and the requirements of OHA established in OAR 410-130-0580. Member Representatives may not give consent for sterilizations.
- (2) Contractor shall submit a signed informed consent form to OHA for each Member that received either a hysterectomy or sterilization service as described in Section 11.a. Contractor may submit copies of informed consent forms upon receipt or when notified by OHA that a qualifying encounter claim has been identified.
- (3) OHA will notify Contractor no later than 30 days past the end of each calendar quarter of Contractor’s Members who received a hysterectomy or sterilization service. Contractor in turn shall supply the informed consent within 30 days of notification to the Contractor’s designated Encounter Data Liaison.
- (4) OHA in collaboration with Contractor reconciles all hysterectomy or sterilization services with informed consents with the associated encounter Claims by either:
 - (a) Confirming the validity of the consent and notifying Contractor that no further action is needed,
 - (b) Requesting a corrected informed consent form, or
 - (c) Informing Contractor the informed consent is missing or invalid and the payment must be recouped and the associated encounter Claim must be changed to reflect no payment made for service(s).
- (5) Contractor will be subject to overpayment recovery as described in Exhibit D, Section 7 of the Contract for failure to comply with the requirements of this section.

e. Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) Prevention, Counseling and Testing Services

Members may receive Covered Services for Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome Prevention, Counseling and Testing from any OHA Provider. To the extent the Member chooses to receive such services without Contractor's authorization from a Provider other than Contractor or its Subcontractors, Contractor is not be responsible for payment, Medical Case Management, or Record Keeping.

f. Post Hospital Extended Care (PHEC) Coordination

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

g. Coordinated Care Services for Members and Long Term Psychiatric Care (LTPC)

- (1) Age 17 and Under: *(add reference to Schedule 2.2) and (add reference to Schedule 2.3)*
 - (a) If Contractor believes a Member is appropriate for LTPC, Contractor shall request a LTPC determination from the applicable OHA mental health program. The Medicaid Policy Unit staff will render a determination within seven working days of receiving a completed request, if the Member is age 17 and under, as described in Schedule 2.2, *Procedure for LTPC Determinations for OHP Members age 17 and Under*;
 - (b) The AMH Child and Adolescent Mental Health Specialist will respond to Contractor no more than seven working days following the date OHA receives a completed request for LTPC determination form.
 - (c) Contractor shall work with the AMH Child and Adolescent Mental Health Specialist in managing admissions and discharges to LTPC (SCIP and SAIP programs).
 - (d) The Member will remain enrolled with the Contractor for delivery of SCIP and SAIP services. Contractor shall bear care coordination responsibility for the entire length of stay, including admission determination and planning, linking the child

and family team and ICT service provider, services provided by LTPC service provider and transition and discharge planning. Contractor shall ensure that utilization of LTPC is reserved for the most acute and complex cases and only for a period of time to remediate symptoms that led to admission.

(2) Age 18 and over

(a) If Contractor believes a Member: *(add reference to Schedule 2.1)*

(i) Age 18 to age 64 with no significant nursing care needs due to an Axis III disorder of an enduring nature, is appropriate for LTPC, Contractor shall request a LTPC determination from the LTPC reviewer as described in Schedule 2.1, Procedure for LTPC Determinations for Members Age 18-64. Adult Mental Health Services Unit staff will render a determination within three working days of receiving a complete request.

(ii) Age 65 and over, or age 18 to age 64 with significant nursing care needs due to an Axis III disorder of an enduring nature, is appropriate for LTPC, Contractor shall request a LTPC determination from the State hospital-GTS, Outreach and Consultation Service (OCS) Team as described in Schedule 2.3, Procedure for Long Term Psychiatric Care Determinations for Persons Requiring Geropsychiatric Treatment.

(b) A Member is appropriate for LTPC when the Member needs either Intensive Psychiatric Rehabilitation or other tertiary treatment in a State hospital or extended care program, or extended and specialized medication adjustment in a secure or otherwise highly supervised environment; and the Member has received all usual and customary treatment, including, if Medically Appropriate, establishment of a Medication Management Program and use of a Medication Override Procedure.

(c) OHA will cover the cost of LTPC of Members age 18 to 64 determined appropriate for such care beginning on the effective date specified below and ending on the date the Member is discharged from such setting.

If a Member is ultimately determined appropriate for LTPC, the effective date of such determination is either:

(i) Within three working days of the date AMH Adult Mental Health Services Unit staff receives a completed Request for LTPC Determination for Persons Age 18 to 64 form; or

(ii) The date the State hospital -GTS OCS Team receives a completed Request for LTPC Determination for Persons Requiring State hospital-GTS; or

(iii) In cases where OHA and Contractor mutually agree on a date other than these dates, the date mutually agreed upon; or

(iv) In cases where the Clinical Reviewer determines a date other than a date described above, the date determined by the Clinical Reviewer.

In the event Contractor and AMH Adult Mental Health Services Unit staff disagree about whether a Member 18 to 64 is appropriate for LTPC, Contractor may request, within three working days of receiving notice of the LTPC determination, review by an independent Clinical Reviewer. The determination of the Clinical Reviewer will be deemed the determination of OHA for purposes of this Contract. If the Clinical Reviewer ultimately determines that the Member is appropriate for LTPC, the effective date of such determination will be the date specified above Paragraph (c). The cost of the clinical review will be divided equally between Contractor and OHA.

- (d) For Members age 18 and older, Contractor shall work with the appropriate AMH Team in managing admissions to and discharges from LTPC for Members who require such care at a State hospital.
- (e) For the Member age 18 and over, including those Members in the long term geropsychiatric care at the State hospitals, Contractor shall work with the Member to assure timely discharge from LTPC to an appropriate community placement.
- (f) For the Member and the parent or guardian of the Member, the care coordinator and the child and family team will work to assure timely discharge from a psychiatric residential treatment facility to an appropriate community placement.
- (g) Contractor shall authorize and reimburse Care Management services that are sufficient in amount, duration or scope to reasonably be expected to achieve the purpose for which the services are provided to Members receiving care through licensed community treatment programs.
- (h) Contractor shall ensure that any involuntary treatment provided under this Contract is provided in accordance with administrative rule and statute, and shall coordinate with the CMHP Director in assuring that all statutory requirements are met. Contractor shall work with the CMHP Director in assigning a civilly committed Member to any placement and participate in circuit court hearings related to planned placements, if applicable.

h. Acute Inpatient Hospital Psychiatric Care

Contractor shall provide Acute Inpatient Hospital Psychiatric Care for Members who do not meet the criteria for LTPC.

i. Adult Mental Health

Contractor shall provide oversight, care coordination and transition and planning management of Members within the targeted population of AMH to ensure culturally and linguistically appropriate community-based care is provided in a way that Members are served in a most natural environment possible and that the use of institutional care is minimized. Contractor shall adapt the intensity, frequency and blend of these services to the mental health needs of the Member, based on a standardized assessment tool approved by OHA.

j. Children's Mental Health

Contractor shall coordinate admissions to and discharges from Acute Inpatient Hospital Psychiatric Care for Members 17 and under in the care and custody of DHS Children, Adults,

and Family Services or OYA in coordination with the care coordinator. For a Member 17 and under placed by DHS CAF through a Voluntary Child Placement Agreement (SCF form 499), Contractor shall also coordinate with such Member's parent or legal guardian.

(1) Integrated Service Array (ISA) for Children and Adolescents

- (a)** The ISA is a range of service components for children and adolescents, through and including age 17. These services target the population with severe mental or emotional disorders whose needs have not been adequately addressed in traditional settings. Contractor shall ensure that the ISA will be recovery focused, family guided, and time limited based on Medically Appropriate criteria.
- (b)** Contractor shall develop and implement a system for the ISA that provides cost effective, comprehensive and individualized care to children and their families.
- (c)** Contractor shall establish a system that promotes collaboration, within laws governing confidentiality, between mental health, child welfare, juvenile justice, education, families, and other community partners in the treatment of children with serious emotional, mental health and behavioral challenges.
- (d)** Contractor shall ensure access to referral and screening at multiple entry points.
- (e)** Contractor shall provide services that are family-driven, strengths-based, culturally and linguistically appropriate, and that enhance and promote quality, community-based service delivery.
- (f)** Contractor shall adopt policies and procedures to assess all Members who are children and adolescents suspected of having significant mental or emotional disorders.
- (g)** Contractor shall use the Child and Adolescent Service Intensity Instrument (CASII) as the statewide tool to assist in the determination for ISA services for children age 6 and older. For children 5 and younger, the statewide tool will be the Early Childhood Service Intensity Instrument (ECSII).
- (h)** Contractor shall prioritize children with the most serious mental health needs for the ISA who have a mental health diagnosis that is on or above the funded line of the OHP prioritized list of health services. This mental health diagnosis must be the focus of the ISA and the treatment plan. In addition to considering the level of service intensity need indicated by the CASII or ECSII score, Contractor shall take into consideration factors including, but not limited to:
 - (i)** Exceeding usual and customary services in an outpatient setting;
 - (ii)** Multiple agency involvement;
 - (iii)** History of one or more out-of-home placements;
 - (iv)** Significant risk of out-of-home placement;
 - (v)** Frequent or imminent admission to acute inpatient psychiatric hospitalizations or other intensive treatment services;

- (vi) Caregiver stress;
- (vii) School disruption due to mental health symptomatology;
- (viii) Elevating or significant risk of harm to self or others; and
- (ix) For children birth to 5:
 - (A) History of abuse or neglect;
 - (B) Conditions interfering with parenting, such as poverty, substance abuse, mental health problems, and domestic violence, and
 - (C) Significant relationship disturbance between parent(s) and child.
- (i) Contractor shall clearly communicate the ISA determination process to Family members, guardians, and community partners, and shall encourage ISA referrals from multiple sources, including families, Allied Agencies, schools, juvenile justice, the faith community and health care providers.
- (j) Contractor shall make decisions regarding ISA determinations and referrals to services within three working days consistent with Contractor's policies and procedures.
- (k) For Members meeting the determination process outlined in Paragraph (B) above, for intensive treatment services have access to care coordination, Contractor shall have available a child and family team planning process and access to the ISA.
- (l) Contractor shall continue to provide services consistent with access standards identified in this Contract, for the time period between level of service intensity determination review and approval and implementation of the service plan.
- (m) Contractor shall submit written policies and procedures for CASII and ECSII administration and ISA determination processes to AMH's Mental Health Medicaid Policy Unit by February 1st of each year. The policy unit will review the policies and procedures and notify Contractor of its determination of the review and approval within 30 days of receipt.
- (n) Contractor shall ensure that admissions to psychiatric residential treatment services are consistent with the admission and certification requirements of 42 CFR 456.481.
- (o) Contractor shall ensure that Service Coordination will be provided by a person or persons who have a strong child and adolescent mental health background, extensive knowledge of the children's system of care, and experience working with families.
- (p) Though Community Care Coordination, Contractor shall provide guidance and Case Management services in the planning, facilitating, and coordination of the child's Service Coordination plan.

- (q) Contractor shall have a child and family team assist in the development of the Service Coordination plan. The team may include the child, if appropriate, Family members, child serving agencies involved with the child, school, culturally specific community based organizations and other community supports identified by the Family.
- (r) Contractor's child and family team shall support and help facilitate access to a culturally and linguistically appropriate combination of services, informal and formal supports, and other community resources.
- (s) Contractor shall develop and implement a Community Care Coordination Committee that is a community level planning and decision making body to provide practice-level consultation, identify needed community services and supports, and provide a forum for problem solving to families, ISA providers, child serving agencies, and child and family teams. The Community Care Coordination Committee must have representation of the local system of care that includes Consumer and Family members, child serving providers, child and family advocates, culturally specific community based organizations, and other local stakeholders representative of the local system of care.
- (t) Contractor shall develop and implement a regional or local children's mental health system advisory council. The advisory council will advise Contractor and provide oversight of the local or regional mental health policies and programs for the ISA, as well as ensure continuous quality assessment/performance improvement (QA/PI).
- (u) Contractor's advisory council shall have representation from child welfare, juvenile justice, education, developmental disabilities, physical health plan, ISA providers, and other local or regional community partners representative of the local system of care, culturally specific community based organizations, culturally diverse populations of mental health Consumers and their Family members.
- (v) Contractor's advisory council shall have representation by Consumers, Family members and child and family advocates comprising a minimum of 51% of total membership, with half of such representation consisting of Members who are adolescent Consumers and family members of Members who are child and adolescent Consumers.
- (w) Contractor shall work closely with OHA to ensure continuous Enrollment for children and adolescents determined as meeting the criteria for the ISA who are placed in treatment facilities outside Contractor's Service Area, as defined in Part IV of this Contract. Contractor shall notify OHA when a Member is admitted to an out of area program, as well as when the Member is scheduled for discharge from the program. OHA staff will make the system adjustments that are necessary to accomplish continuous Enrollment with Contractor. Eligibility determinations will not be affected and will continue to be subject to the OHA criteria for participation in the OHP.
- (x) Contractor shall develop a process to ensure that funding intended and allocated for children's mental health is used for that purpose.

- (y) Performance targets for the percentage of expenditures on services to children and adolescents must equal the percentage of revenues based on child and adolescent Members.
- (z) Contractor shall serve any Member meeting criteria for the ISA, as described in this section, by a provider certified to provide intensive community based treatment services under OAR 309-032-1500 to 309-032-1565.
- (aa) Contractor shall establish contractual relationships or memorandums of understanding with Providers certified to provide intensive treatment services that demonstrate adequate and sufficient capacity to provide the ISA.
- (bb) Contractor shall adopt policies and procedures in place to ensure timely reimbursement to Providers participating in the ISA.
- (cc) Whenever Contractor reimburses a non-contract provider of psychiatric day treatment services or Psychiatric Residential Treatment Services for services identical to those purchased by OHA through direct contracts, Contractor's reimbursement shall be no less than the amount paid by OHA for the same services.
- (dd) Contractor shall adopt policies and procedures describing the admission and discharge criteria for a child or adolescent requiring the ISA level of care, with a process that includes the active participation of the Family, Allied Agencies, and other persons involved in the child's care.
- (ee) Contractor shall submit additional reports and information as identified by OHA for the purposes of QA/PI activities of the ISA. Contractor shall work with OHA to identify specific outcomes and performance measures that will be tracked and reported on a quarterly basis.
- (ff) OHA will conduct an annual survey of Family members and caregivers of child and adolescent Members receiving Covered Services and will provide aggregate results and raw data received from Contractor's members to the Contractor.
- (gg) Contractor shall submit additional reports and information derived from this aggregate data as identified by OHA for the purposes of QA/PI activities of the ISA.
- (hh) Contractor shall report on ISA system clinical outcomes by submitting a completed ISA Children's System Progress Review report, administered upon entry, quarterly and upon exit, while member receives ISA services. Data shall be reported no later than 30 days after entry into ISA services. Data shall be submitted electronically to the following web address:
<https://apps.state.or.us.cfl/amh>.
- (ii) In addition to the utilization management requirements stated in this Contract, Contractor shall ensure that admissions to psychiatric residential treatment programs are consistent with the admission and certification requirements of 42 CFR 456.481 and 441.150 through 441.156.

k. Chemical Dependency

Contractor shall provide Chemical Dependency Services to eligible Members, which include outpatient treatment services, Opiate Substitution Services, and Intensive outpatient treatment services. For purposes of this Contract, AMH rules and criteria applicable to outpatient treatment services are located in Integrated Services and Supports Rules (ISSR) OAR 309-032-0000, the AMH rules and criteria applicable to synthetic opiate treatment services located in OAR 415-020-0000 and the AMH rules and criteria applicable to detoxification centers located in OAR 415-0050-0000. For technical assistance related to this section of this Contract, the AMH contact will be the OHP Alcohol and Drug Specialist, Addictions and Mental Health Medicaid Policy Unit.

- (1) Contractor shall make decisions about access to Chemical Dependency Services, continued stay, discharges, and referrals based upon AMH approved criteria, which are deemed to be Medically Appropriate. Contractor shall ensure that employees or Subcontractors who evaluate Members for access to and length of stay in Chemical Dependency Services have the training and background in Chemical Dependency Services and working knowledge of American Society of Addiction Medicine (ASAM) Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition-Revised (PPC-2R). Contractor shall participate with AMH in a review of AMH provided data about the impact of these criteria on service quality, cost, outcome, and access.
- (2) Contractor shall consider each eligible Member's needs and, to the extent appropriate and possible, provide specialized Chemical Dependency Services designed specifically for the following groups as set forth in AMH administrative rules: a) adolescents, taking into consideration adolescent development, b) women, and women's specific issues, c) ethnic and racial diversity and environments that are culturally and linguistically relevant, d) intravenous drug users, e) people involved with the criminal justice system, and f) individuals with co-occurring disorders.
- (3) Consistent with Appendix G, Framework Scope of Work Part 4, Section 6, Subsection a, Services Coordination for Non-Capitated Services, Contractor shall coordinate referral and follow-up of Members to Non-Capitated Services such as residential treatment services, and community detoxification. Contractor's employees or Subcontractors providing Chemical Dependency Services shall provide to Member, to the extent of available community resources and as clinically indicated, information and referral to community services which may include, but are not limited to: child care, elder care, housing, transportation, employment, vocational training, educational services, mental health services, financial services, and legal services.
- (4) As an alternative to Inpatient Hospital Detoxification, Contractor shall where Medically Appropriate provide medically monitored detoxification in a non-hospital based facility. Admissions for members to this level of care must be consistent with level III. 7-D of the ASAM PPC-2R. Facilities or programs providing medically monitored detoxification services must have a letter of approval or license form OHA.
- (5) Contractor shall authorize and pay for at least culturally and linguistically appropriate outpatient Chemical Dependency Services to eligible Members who meet ASA PPC-2R criteria for residential treatment services, when residential treatment services are not immediately available.

- (6) Contractor shall require employees or Subcontractors providing Chemical Dependency Services to provide AMH, within 30 days of admission or discharge, with all information required by AMH's most current publication "Client Process Monitoring System" (CPMS).
- (7) Contractor shall use AMH approved chemical dependency screening tools for prevention, early detection, brief intervention and referral to chemical dependency treatment. Contractor may submit alternative screening tools to AMH for review and possible approval. For a list of the AMH approved screening tools, Contractor shall contact the OHP Alcohol and Drug Specialist.
- (8) Contractor shall make a good faith effort to screen all eligible Members and provide prevention, early detection, brief intervention and referral to chemical dependency treatment who are in any of the following circumstances: a) at an initial contact or routine physical exam, b) at an initial prenatal exam, c) when the Member shows evidence of chemical dependency or abuse (as noted in the AMH approved screening tools), or d) when the Member over-utilizes Capitated Services.
- (9) Contractor shall ensure that individuals or programs have a letter of approval or license from AMH for the Chemical Dependency Services they provide and meet all other applicable requirements of this Contract, except that providers under The Drug Addiction Treatment Act of 2000, Title 42 Section 3502 Waiver may treat and prescribe Buprenorphine for opioid addiction in any appropriate practice setting in which they are otherwise credentialed to practice and in which such treatment would be Medically Appropriate.
- (10) Contractor shall inform all eligible Members using culturally and linguistically appropriate means that chemical dependency outpatient, intensive outpatient and medication assisted treatment services, including opiate substitution treatment, are included in the OHP Plus and OHP Standard Benefit package consistent with OAR 410-141-3300.
- (11) Contractor shall provide covered culturally and linguistically appropriate Chemical Dependency Services for any eligible Member who meets admission criteria for outpatient, intensive outpatient and medication assisted treatment including opiate substitution treatment, regardless of prior alcohol/other drug treatment or education.
- (12) Contractor shall comply with the following access requirements: Eligible Members are seen the same day for emergency chemical dependency treatment care. Eligible Members, including pregnant women, are seen within 48 hours for urgent chemical dependency treatment care. Eligible Members, including intravenous drug users, are seen within 10 days or the community standard for routine chemical dependency treatment care.
- (13) In addition to any other confidentiality requirements described in this Contract, Contractor shall follow the federal (42 CFR Part 2) and State (ORS 179.505, 430.397, 430.399) confidentiality laws and regulations governing the identity and medical/client records of Members who receive Chemical Dependency Services.
- (14) Contractor shall identify and ensure that Members have access to culturally and linguistically appropriate specialized programs in each Service Area in the following categories: drug court referrals, Children, Adults and Families (CAF) referrals, Job

Opportunities and Basic Skills (JOBS) referrals, and referrals for persons with co-occurring disorders.

- (15) Contractor shall provide Members with culturally and linguistically appropriate alcohol, tobacco, and other drug abuse prevention/education that reduces substance abuse risk to Members. Contractor's prevention program shall meet or model national quality assurance standards. Contractor shall have mechanisms to monitor the use of its preventive programs and assess their effectiveness on its Members.

l. Medication Management

- (1) Except as otherwise provided in this Contract, prescription drugs are a Covered Service for funded Condition/Treatment Pairs, and Contractor shall pay for Prescription Drugs. Contractor shall provide covered prescription drugs in accordance with OAR 410-141-3070. Prescription drugs and drug classes covered by Medicare Part D for Full Dual Eligible clients are not a Covered Service. OHA will continue to cover selected drugs that are excluded from Medicare Part D coverage, pursuant to OAR 410-120-1210.
- (2) Contractor shall develop policies and procedures to ensure children, especially those in custody of DHS, who need or who are being considered for psychotropic medications, receive medications that are for medically accepted indications. Contractor shall prioritize service coordination and the provision of other mental health services and supports for these children.

m. Tobacco Dependency

Contractor shall provide for: culturally and linguistically appropriate tobacco dependence Assessments, systematically and on-going; and cessation intervention, treatment, and counseling services consistent with recommendations listed in the Public Health Services Clinical Practice Guideline Treating Tobacco Use and Dependence: 2008 Update located at: <http://www.ahrq.gov/path/tobacco.htm>. Contractor shall make these services available to all Members assessed to use tobacco products including smokeless, dissolvable, electronic vapor, pipes and cigars. Contractor shall establish a systematic mechanism to document and report dependency and cessation services. Contractor may refer to accepted published evidence-based community standards, the national standard or as outlined in OAR 410-130-0190.

APPLICANT MAY PROPOSE ADDITIONAL LANGUAGE FOR PART 2, SEE APPENDIX B

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

1. Member Engagement

APPLICANT MAY PROPOSE LANGUAGE FOR THIS SECTION; SEE APPENDIX A

2. Member Rights under Medicaid

Consistent with Member rights and responsibilities under Medicaid law, Contractor shall:

- a.** Ensure Members are aware that a second opinion is available from a qualified health care professional within the Provider Network, or that the Contractor will arrange for the Member to obtain a qualified health care professional from outside the network, at no cost to the Member.
- b.** Provide equal access for both males and females under 18 years of age to appropriate facilities, services and treatment under this Contract, consistent with OHA obligations under ORS 417.270.
- c.** Require, and cause its Participating Providers to require, that Members receive information on available treatment options and alternatives presented in a manner appropriate to the Member's condition and ability to understand.
- d.** Allow each Member the right to be actively involved in the development of treatment plans if Covered Services are to be provided and to have Family involved in such treatment planning.
- e.** Allow each Member the right to request and receive a copy of his or her own Health Record, (unless access is restricted in accordance with ORS 179.505 or other applicable law) and to request that the records be amended or corrected as specified in 45 CFR Part 164.
- f.** Ensure that each Member has the right to have access to Covered Services which at least equals access available to other persons served by Contractor.
- g.** Ensure Members are free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliations specified in federal regulations on the use of restraints and seclusion.
- h.** Ensure, and cause its Participating Providers to ensure, that each Member is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the Contractor, its staff, Subcontractors, Participating Providers or OHA, treat the Member. Contractor shall not discriminate in any way against Contractor's Members when those Members exercise their rights under the OHP.
- i.** Ensure that any cost sharing authorized under this Contract for Members is in accordance with 42 CFR 447.50 through 42 CFR 447.60 and with the General Rules.
- j.** Notify Members eligible for the OHP Plus Benefit Package of their responsibility for paying a co-payment for some services, as specified in OAR 410-120-1230.

3. Informational Materials and Education of Members and Potential Members

- a.** Contractor shall have a mechanism to help Members and Potential Members understand the requirements and benefits of Contractor's integrated and coordinated care plan. Contractor shall

develop and provide written information materials and educational programs consistent with the requirements of OAR 410-141-3280, 410-141-3300 and 42 CFR 438.10.

- b. Contractor shall develop a Member handbook and submits it to OHA for review and approval. OHA will review and approve such materials within ten Business Days.
- c. Contractor shall submit to OHA any changes to the Member handbook for review and approval prior to distribution to Members.

4. Grievance System

- a. Contractor shall have a Grievance System, supported with written procedures, for Members that includes a Grievance process, Appeal process and access to Contested Case Hearings. Contractor's Grievance System shall meet the requirements of Exhibit I, OAR 410-141-3260 through 410-141-0266 and 42 CFR 438.402 through 438.414. The Grievance System must include Grievances and Appeals related to requests for accommodation in communication or provision of services for Members with a disability or limited English proficiency. OHA will review the Contractor's procedures for compliance and notify Contractor when approved. Upon any change to the approved procedures, Contractor shall submit the changes to OHA for approval.
- b. Contractor shall provide every Subcontractor, at the time it enters into a subcontract, its OHA approved written procedures for its Grievance System.

5. Enrollment and Disenrollment

a. Enrollment

- (1) Enrollment is the process by which OHA signs on with Contractor or another prepaid health plan those individuals who have been determined to be eligible for health services under the OHP or the Children's Health Insurance Program.
- (2) Except as provided in ORS 414.631 and OAR 410-141-3060, a person who is eligible for or receiving health services must be enrolled in a CCO to receive the health services for which the person is eligible.
- (3) An individual becomes a Member for purposes of this Contract as of the date of Enrollment with Contractor. As of that date, Contractor shall provide all Covered Services to such Member as required by the terms of this Contract.
 - (a) For persons who are enrolled on the same day as they are admitted to the hospital or, for children and adolescents admitted to psychiatric residential treatment services (PRTS), Contractor is responsible for said services.
 - (b) If the person is enrolled after the first day of hospital stay or PRTS, the person will be Disenrolled, and the date of Enrollment shall be the next available Enrollment date following discharge from hospital services or PRTS.
- (4) The provisions of this section apply to all CCO enrollment arrangements whether Enrollment is mandatory or voluntary. If Enrollment is mandatory, OHA will sign on such individuals with a CCO selected by the individual. If an eligible individual does not select a CCO, OHA may assign the person to a CCO selected by OHA. Contractor shall

have an open Enrollment period at all times, during which Contractor shall accept, without restriction, all eligible OHP Clients in the order in which they apply and are signed on with Contractor by OHA, unless Contractor's Enrollment is closed under paragraph (7).

- (5) Contractor shall not discriminate against individuals eligible to enroll on the basis of health status, the need for health services, race, color, or national origin, and shall not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin.
- (6) Contractor may be assigned OHP Clients during periods of open Enrollment, during which periods Contractor shall accept, without restriction, all eligible OHP Clients in the order in which they apply and are signed on by OHA in accordance with the enrollment rules in OAR 410-141-3060.
- (7) Enrollment with Contractor may be closed by OHA, or by Contractor notifying the designated OHA CCO Coordinator, because Contractor's maximum Enrollment has been reached or for any other reason mutually agreed to by OHA and Contractor, or as otherwise authorized under this Contract or OAR 410-141-3060.
- (8) If OHA enrolls an OHP Client with Contractor in error, and the erroneously enrolled OHP Client has not received services from Contractor, OHA may retroactively Disenroll the Member from Contractor and enroll the OHP Client with the originally intended contractor up to 60 days from the date of the erroneous Enrollment, and the Capitation Payment to Contractor will be adjusted accordingly.
- (9) Contractor shall provide Enrollment validation as described in Exhibit B, Part 8, Section 7 of this Contract.

b. Disenrollment

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

- (1) An individual is no longer a Member for purposes of this Contract as of the effective date of the individual's Disenrollment from Contractor. As of that date, Contractor is no longer required to provide services to such individual by the terms of this Contract, unless the Member is hospitalized at the time of Disenrollment. In such an event, Contractor is responsible for inpatient hospital services until discharge or until the Member's PCP determines that care in the hospital is no longer Medically Appropriate. OHA will assume responsibility for other services not included in the Diagnostic Related Group (DRG) applicable to the hospitalization.
- (2) If Disenrollment occurs due to an illegal act which includes Member or Provider Medicaid fraud, Contractor shall report to OHA Office of Payment Accuracy and Recovery, consistent with 42 CFR 455.13 by one of the following methods: Fraud hotline 1-888-FRAUD01 (1-888-372-8301); or Report fraud online at https://apps.state.or.us/cf1/OPR_Fraud_Ref/index.cfm?act=evt.subm_web

- (3) A Member may be Disenrolled from Contractor at the request of the Member in accordance with OAR 410-141-3080
- (4) OHA may Disenroll a Member upon request by Contractor in accordance with OAR 410-141-3080:
 - (a) Contractor submits requests for Disenrollment in writing, detailing the specific reason as required in OAR 410-141-3080 and this Contract, to their CCO Coordinator for prior approval except where otherwise specified in OAR 410-141-3080.
- (5) Contractor may not request Disenrollment of a Member for reasons related to:
 - (a) An adverse change in the Member's health status;
 - (b) Utilization of health services;
 - (c) Diminished mental capacity;
 - (d) Uncooperative or disruptive behavior resulting from the Member's special needs (except when the continued Enrollment seriously impairs Contractor's ability to furnish services to either this Member or other Members);
 - (e) A disability or any condition that is a direct result of their disability, unless otherwise specified in OHP Administrative Rule; or
 - (f) Other reasons specified in OAR 410-141-3080(2)(B).
- (6) The effective date of Disenrollment when requested by a Member will be the first of the month following OHA's approval of Disenrollment. The effective date of Disenrollment for Members who Disenroll from Contractor's Medicare Advantage plan will be the first of the month that their Medicare Advantage Disenrollment is effective. If OHA fails to make a Disenrollment determination by the first day of the second month following the month in which the Member files a request for Disenrollment, the Disenrollment is considered approved.
- (7) If OHA Disenrolls a Member retroactively, OHA will recoup any CCO Payments received by Contractor after the effective date of Disenrollment. If the Disenrolled Member was otherwise eligible for the OHP, services the Member received during the period of the retroactive Disenrollment may be eligible for fee-for-service payment under OHA rules.
- (8) If OHA Disenrolls a Member due to an OHA administrative error, and the Member has not received services from another contractor, the Member may be retroactively re-enrolled with Contractor up to 60 days from the date of Disenrollment.
- (9) Disenrollment required by adjustments in Service Area or Enrollment is governed by Exhibit B, Part 3, Section 5 of this Contract.

c. Member Benefit Package Changes

The Weekly and Monthly Enrollment file (as described in Exhibit B, Part 3, Section 7 of this Contract) will identify Contractor's Member current eligibility status for either the OHP Plus or

the OHP Standard Benefit Package. The file does not include any historical data on Member's eligibility status. A benefit package change due to a Member's eligibility status may constitute Disenrollment.

d. Enrollment Reconciliation

- (1) Contractor shall reconcile the OHA 834 Enrollment transaction file, sent by OHA to Contractor monthly, to Contractor's current Member information in its Health Information System (HIS) for the same period (for purposes of this report refer to the previous month's data) which is known as a look back period.
- (2) Contractor shall report to OHA, using the Enrollment Reconciliation Certification Forms, which are located at: [\(enter link\)](#). Contractor's determination of OHA 834 Enrollment transaction files shall be reported as follows:
 - (a) If there are no discrepancies, Contractor shall complete, sign, date and submit "Enrollment Reconciliation Certification- No Discrepancies", found at the above link, to OHA within 14 calendar days of receipt of the OHA 834 Enrollment transaction file, or
 - (b) If there are discrepancies, Contractor shall complete, sign, date and submit, "Enrollment Reconciliation Certification - Form 2 – Discrepancies Found", found at the above link, to OHA within 14 calendar days of receipt of OHA's Enrollment transaction file.
- (3) OHA will verify, and if applicable correct, all discrepancies reported to OHA on "Enrollment Reconciliation - Discrepancies Found", prior to the next Enrollment transaction file.

6. Identification Cards

Contractor shall provide an ID card to members which contains simple, readable and usable information on how to access care in an urgent or emergency situation. Such ID cards confer no rights to services or other benefits under the OHP and are solely for the convenience of the Members and Providers.

7. Marketing

- a. Contractor may not initiate contact or Market independently to potential OHP Clients, directly or through any agent or independent contractor, in an attempt to influence an OHP Client's Enrollment with Contractor, without the express written consent of OHA. Contractor may not conduct, directly or indirectly, door-to-door, telephonic, mail, electronic, or other Cold Call Marketing practices to entice the OHP Client to enroll with Contractor, or to not enroll with another Contractor. Contractor may not seek to influence an OHP Client's Enrollment with the Contractor in conjunction with the sale of any other insurance. Contractor shall apply the prohibitions of this paragraph to its agents, Subcontractors, and Subcontractor's agents.
- b. Contractor shall provide to OHA, for approval prior to use, the form and content of all materials that reference benefits or coverage and Marketing Materials. In reviewing and approving Marketing Material, OHA will consult with a medical care advisory committee. Any Contractor representative or agent serving on the advisory committee is excused from review of Contractor's materials. Messages strictly for the purpose of health promotion, health education or outreach distributed to Contractor's existing Members do not require prior approval from OHA.

- c. Contractor shall ensure that Members are not intentionally misled about their options by Contractor's staff, activities or materials. Contractor's materials may not contain inaccurate, false, confusing or misleading information.
- d. Contractor shall provide copies of all written Marketing Materials to all OHA offices within Contractor's entire Service Area(s). Contractor shall make no assertion or statement (whether written or oral) that:
 - (1) The Potential Member and Member must enroll with Contractor in order to obtain benefits or in order to not lose benefits; or
 - (2) The Contractor is endorsed by CMS, the federal or State government, or similar entity.
- e. Contractor shall make information concerning Client Notices, Grievances, Appeals and Contested Case Hearings available in appropriate formats (e.g. video or audio in multiple languages) for low literacy and limited English proficient members in all clinics, Participating Provider offices, and other service locations frequented by Members.
- f. Contractor shall comply with the information requirements of 42 CFR 438.10 to ensure that, before enrolling, the Potential Member receives, from the Contractor or OHA, the accurate oral and written information he or she needs to make an informed decision on whether to enroll with the Contractor.
- g. For purposes of this Section, "Cold Call Marketing," "Marketing," and "Marketing Materials" have the meanings defined in OAR 410-141-3000 or 42 CFR 438.104, whichever is broader.

8. Mental Health Conditions that may Result in Involuntary Psychiatric Care

- a. Contractor makes a reasonable effort to provide Covered Services on a voluntary basis and consistent with current Declaration for Mental Health Treatment in lieu of involuntary treatment.
- b. Contractor adopts written policies and procedures describing the appropriate use of Emergency Psychiatric Holds consistent with ORS 426 and alternatives to involuntary psychiatric care when a less restrictive voluntary service will not meet the Medically Appropriate needs of the Member and the behavior of the Member meets legal standards for the use of an Emergency Psychiatric Hold.
- c. Contractor only uses psychiatric inpatient facilities and non-inpatient facilities certified by OHA under OAR 309-033-0200 through 309-033-0340.
- d. Contractor complies with ORS Chapter 426, OAR 309-033-0200 through 309-033-0340 and 309-033-0400 through 309-033-0440 for involuntary Civil Commitment of those Members who are civilly committed under ORS 426.130.
- e. If Contractor believes a Member, over age 18 with no significant nursing care needs due to an Axis III disorder, is appropriate for Long Term Psychiatric Care (state hospital level of care), the Contractor shall request a LTPC determination from the OHA LTPC reviewer.
- f. Contractor shall assure that any involuntary treatment provided under this Contract is provided in accordance with administrative rule and statute, and shall coordinate with the CMHP Director in assuring that all statutory requirements are met. Contractor shall also work with the CMHP

Director in assigning a civilly committed Member to any placement and participate in circuit court hearings related to planned placements, if applicable.

APPLICANT MAY PROPOSE ADDITIONAL LANGUAGE FOR PART 3; SEE APPENDIX B

DRAFT

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

1. Integration and Coordination

Contractor shall develop, implement and participate in activities supporting a culturally and linguistically appropriate continuum of care that integrates mental health, addiction, dental health and physical health interventions in ways that are seamless and whole to the Member. Integration activities may span a continuum ranging from communication to coordination to co-management to co-location to the fully integrated Patient Centered Primary Care Home.

- a. Contractor shall ensure that in coordinating care, the Member's privacy is protected consistent with the confidentiality requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable, and consistent with other State law or Federal regulations governing privacy and confidentiality of health records.
- b. Contractor shall demonstrate involvement in integration activities such as, but not limited to:
 - (1) Enhanced communication and coordination between Contractor and DCOs, mental health and Chemical Dependency Providers;
 - (2) Implementation of integrated Prevention, Early Intervention and wellness activities;
 - (3) Development of infrastructure support for sharing information, coordinating care and monitoring results;
 - (4) Use of screening tools, treatment standards and guidelines that support integration;
 - (5) Support of a shared culture of integration across coordinated care plans and service delivery systems; and:
 - (6) Implementation of a system of care approach, incorporating models such as the Four Quadrant Clinical Integration Model of the National Council for Community Behavioral Healthcare or Wraparound for children with behavioral health disorders.

2. Adjustments in Service Area or Enrollment

- a. If Contractor experiences a Material Change, or is engaged in the termination or loss of a medical Provider or group or affected by other factors which have significant impact on access in that Service Area and which may result in transferring a substantial number of Members to other Providers employed or subcontracted with Contractor, Contractor shall provide OHA with a written plan for transferring the Members and an updated Provider Report, Exhibit G, at least 90 days prior to the date of such action, notwithstanding the Contract renewal date. Contractor shall remain responsible for maintaining sufficient capacity and solvency, and providing all Capitated Services through the end of the 90-day period.
 - (1) If Contractor must terminate a medical Provider or group due to circumstances that could compromise Member care, less than the required notice to OHA may be provided with the approval of OHA.
 - (2) If a medical Provider or group terminates its subcontract or employment with Contractor or if Contractor is affected by circumstances beyond Contractor's control and the

Contractor cannot reasonably provide the required 90 days notice, less than the required notice to OHA may be provided with the approval of OHA.

- (3) If Contractor cannot demonstrate sufficient Provider capacity, OHA may seek other avenues to provide services to Members. If OHA determines that some or all of the affected Members must be Disenrolled from Contractor, the applicable provisions of this Section shall apply.

b. If Contractor experiences a Material Change, or is engaged in the termination or loss of a medical Provider or group or affected by other factors which has significant impact on access in that Service Area and which may result in reducing or terminating Contractor's Service Area or Disenrolling a substantial number of Members from Contractor, Contractor shall provide OHA with a written notice and a plan for implementation (which may include an intent to transfer its Members in the Service Area to a Contractor designated by OHA) at least 90 days prior to the date of such action, notwithstanding the Contract renewal date. Contractor shall remain responsible for providing all Capitated Services through the end of the 90-day period, without limitation, for all Members for which the Contractor received a CCO Payment.

- (1) If Contractor must terminate a medical Provider or group due to circumstances that could compromise Member care, less than the required notice to OHA may be provided with the approval of OHA.
- (2) If a medical Provider or group terminates their Subcontract or employment with Contractor or Contractor is affected by other circumstances beyond Contractor's control and the Contractor cannot reasonably provide the required 90 days notice, less than the required notice to OHA may be provided with the approval of OHA.
- (3) If Contractor provides OHA with the required 90-day notice but provides no Letter of Intent to transfer its Members to a designated Contractor within 30 days of the 90-day notice, Members in the affected Service Area will be Disenrolled from Contractor and will be assigned to existing Contractors providing services in the affected Service Area(s) who can demonstrate Provider capacity.
- (4) If Contractor provides OHA with the required 90-day notice and also provides a Letter of Intent to transfer its Members to a designated Contractor, and OHA determines that the designated Contractor(s) will have sufficient Provider capacity as of the date of the proposed transfer, OHA may approve the Disenrollment and transfer of Members and develop such Contract amendment(s) as may be necessary to effect the transfer.
- (5) OHA may seek other avenues to provide services to the Members in the affected area(s).

c. If Members are required to Disenroll from Contractor pursuant to this Section 2, Contractor remains responsible for all Capitated Services, without limitation, for each Member until the effective date of Disenrollment. Unless specified otherwise by OHA, Disenrollments shall be effective the end of the month in which the Disenrollment occurs. Contractor shall cooperate in notifying the affected Members and coordinating care and transferring records during the transition to the designated contractor or to the contractor that has been assigned to the Member or to such other PCP as may be designated. If OHA must notify affected Members of the change, Contractor shall provide OHA with the name, prime number, and at least one address label for each of the affected Members not less than 45 days prior to the effective Disenrollment date.

- d. Contractor shall complete submission and corrections to encounter data for services received by Members; shall assure payment of valid claims by employees and Subcontractors, and for Non-Participating Providers providing Covered Services to Members; and shall comply with the other terms of this Contract applicable to the dates of service before Disenrollment of Members pursuant to this section. OHA may, in its discretion, withhold 20% of Contractor's CCO Payment until all contractual obligations have been met to OHA's satisfaction. Contractor's failure to complete or ensure completion of said contractual obligations within a reasonable period of time will result in a forfeiture of the amount withheld.
- e. If Contractor is assigned or transferred OHP Clients pursuant to Subsections b. or c. of this section, Contractor accepts all assigned or transferred OHP Clients without regard to the Enrollment exemptions in OAR 410-141-3060. This provision does not apply to a Medicare Advantage plan's full Dual eligible for Medicare and Medicaid Members.
- f. If this Contract is amended to reduce the Service Area and/or to reduce the Enrollment limit, the CCO Payment rates may be recalculated using the methodology described in Exhibit C, Attachment I, as follows:
 - If the calculation based on the reduced Service Area and/or Enrollment limit would result in a rate decrease, this Contract will be amended to reduce the amount of the CCO Payment rates in Exhibit C, Attachment II, effective the date of the reduction of the Service Area and/or Enrollment limit.
- g. If this Contract is amended to expand the Service Area and/or the Enrollment limit, the CCO Payment rates may be recalculated using the methodology described in Exhibit C, Attachment I, as follows:
 - (1) If the calculation based on the expanded Service Area and/or Enrollment limit would result in a rate increase, this Contract will be amended to increase the amount of the CCO Payment rates in Exhibit C, Attachment II, effective the date of the expansion of the Service Area and/or Enrollment limit.
 - (2) If the calculation based on the expanded Service Area and/or Enrollment limit would result in a rate decrease, Contractor's rates will be amended to adjust the rates when the next OHP-wide rate adjustment occurs.

3. Delivery System and Provider Capacity

a. Delivery System Capacity

- (1) As specified in 42 CFR 438.206, Contractor shall maintain and monitor a Provider Panel that is supported with written agreements, and that has sufficient capacity and expertise to provide adequate, timely and Medically Appropriate access to Covered Services to Members across the age span from child to older adult, including Members who are dually eligible for Medicare and Medicaid. In establishing and maintaining the Provider Panel, Contractor shall consider, at a minimum, the following:
 - (a) The anticipated Medicaid Enrollment and anticipated enrollment of individuals dually eligible for Medicare and Medicaid;
 - (b) An appropriate range of preventive and specialty services for the population enrolled or expected to be enrolled in the Service Area;

- (c) The expected utilization of Services, taking into consideration the characteristics and mental health care needs of Members;
 - (d) The number and types (in terms of training, experience, and specialization) of Providers required to provide services under this Contract;
 - (e) The number of Providers who are not accepting new Members; and
 - (f) Contractor's approach to integrated care and care coordination and the use of patient-centered primary care homes.
- (2) Contractor shall allow each Member to choose a Provider within Contractor's Provider Network to the extent possible and appropriate.
 - (3) Contractor shall provide Members with access, as Medically Appropriate, to licensed medical professionals and mental health professionals.
 - (4) Contractor shall demonstrate that the number of Indian Health Care Providers that are Participating Providers are sufficient to ensure timely access to Covered Services within the scope of Covered Services specified under this Contract, for those Native American or Alaska Natives enrolled with the Contractor who are eligible to receive services from such providers, or shall demonstrate that there are no or few Indian Health Care Providers in the Contractor's Service Area(s).
 - (5) Contractor shall identify training needs of its Provider Network and shall address such needs to improve the ability of the Provider Network to deliver Covered Services to Members.
 - (6) If Contractor is unable to provide necessary Covered Services which are culturally and linguistically and Medically Appropriate to a particular Member within its Provider Panel, Contractor shall adequately and timely cover these services out of network for the Member, for as long as Contractor is unable to provide them. Out of network providers must coordinate with Contractor with respect to payment. Contractor shall ensure that cost to Member is no greater than it would be if the services were provided within the Provider Panel.
 - (7) Contractor shall participate in OHA efforts to promote the delivery of services in a Culturally Competent manner to Members, including those with limited English proficiency and diverse cultural and ethnic backgrounds.
 - (8) Contractor shall coordinate its service delivery system planning effort with organized planning efforts carried out by the local mental health authority in its Service Area.

b. Provider Capacity

- (1) Contractor shall maintain and monitor a network of Participating Providers that is supported with written agreements (as specified in Exhibit D, Section 18 and Exhibit B, Part 4, Section 7) and has sufficient capacity to provide adequate, timely and Medically Appropriate Covered Services for Contractor's Members as required by this Contract and under OAR 410-141-3120. Contractor shall establish written policies and procedures in place which comply with the requirements specified in 42 CFR 438.214, which includes

selection and retention of Providers, credentialing and re-credentialing requirements, and nondiscrimination. In establishing and maintaining the network, Contractor shall:

- (a) Complete the Provider Capacity Report as required in Exhibit G as specified in Exhibit B, Part IV, Section 1, Subsection (4) and submit to OHA an update of this Provider Capacity Report at any time there has been a Material Change in Contractor's operations that would affect adequate capacity and services;
- (b) Use Provider selection policies and procedures, in accordance with 42 CFR 438.12 and 42 CFR 438.214, that do not discriminate against particular Providers that serve high-risk populations or specialize in conditions that require costly treatment. If Contractor declines to include individual or groups of Providers in its network, it must give the affected Providers written notice of the reason for its decision;
- (c) Consider the number of Participating Providers who are not accepting new Members; and
- (d) Demonstrate that the number of Indian Health Care Providers that are Participating Providers are sufficient to ensure timely access to Covered Services for those Native Americans or Alaska Natives enrolled with the Contractor who are eligible to receive services from such providers, or demonstrate in the Contractor's service areas that there are no or few Indian Health Care Providers.

4. Evidence-Based Clinical Practice Guidelines

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

5. Health Promotion and Prevention

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

- a. Collect data for Member population service planning and delivery, reported with consideration to implementing state plans for achieving public health objectives and meeting national Healthy People 2020 objectives and Meaningful Use standards.
- b. Provide annual health risk assessment for Members. Assessment may be provided or coordinated through a Members' Patient-Centered Primary Care Home. These assessments will include screening for chronic disease and risk factors such as alcohol, tobacco use and other substance use, high blood pressure, diabetes, depression, breast, colorectal and cervical cancer,

high cholesterol, stress, trauma and other mental health issues with opportunities for education, treatment and follow-up based on results.

- c. Actively promote all health screening methodologies receiving a Grade A or B recommendation by the US Preventive Services Task Force to patients, families, and providers..
- d. Actively promote screenings recommended by Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents (2nd ed., rev.) (1994; 2000; 2002) for pediatric populations to patients, families, and providers.
- e. Demonstrate evidence of partnership with health promotion and local prevention leaders and professionals, including local public health authorities.
- f. Contribute to implementation of the State's comprehensive plans for promotion of physical activity and healthy nutrition, tobacco prevention and older adult and youth suicide prevention.
- g. Contribute to local public health and health promotion planning efforts.
- h. Meet the needs of culturally and linguistically diverse communities and specify the actions Contractor will take to reduce or eliminate health disparities.
- i. Disseminate culturally and linguistically appropriate educational materials that meet members diverse health literacy needs on healthy lifestyles and chronic disease early detection, treatment and self-management at plan and provider levels (provider/hospital Meaningful Use optional criteria).
- j. Assure full compliance with disease reporting to the public health system.
- k. Coordinate the above activities with Members' Patient-Centered Primary Care Home or primary care provider.

6. Patient Centered Primary Care Homes (PCPCH)

Contractor shall include in its network, to the greatest extent possible, Patient-Centered Primary Care Homes recognized by the OHA and provides support for moving providers along the spectrum of the PCPCH model (from Tier 1 to Tier 3).

The following provisions are subject to CMS approval of Oregon's PPACA Section 2703 Medicaid State Plan Amendment (SPA) and related state plan changes needed for federal authorization to implement Oregon's Patient Centered Primary Care Home model in the Medicaid program. Payments described in Subsection (b) will not begin until OHA has received CMS approval. OHA will provide notification to Contractor when necessary approvals have been received.

- a. Contractor shall assist Providers within its delivery system to establish PCPCHs. Contractor expands the availability of PCPCHs to the maximum extent feasible.
- b. Contractor should provide enhanced or additional reimbursement for PCPCH services for all Members within a provider's patient panel, regardless of disease status, and should reflect the PCPCH Tier level achieved. While PCPCH payments should include all Members in a provider's patient panel, the payment amount does not need to be the same for all Members and can be risk-adjusted based on disease severity or other factors.

- c. Contractor shall provide a report to OHA that includes the following:
 - (1) Number of health care teams or clinics meeting PCPCH standards, by tier.
 - (2) Number of primary care practitioners accepting Members in a PCPCH listed out by tier 1, 2 or 3.
 - (3) Number of Members assigned to Providers in PCPCH practices listed out by tier 1, 2 or 3.
 - (4) Number of Members with chronic conditions, as described in the CMS approved State Plan Amendment, listed out by tier 1, 2 or 3.
- d. Contractor shall promote and assist other Providers to communicate and coordinate care with the PCPCH in a timely manner using electronic health information technology to the maximum extent feasible.

7. Subcontract Requirements

Contractor ensures that Subcontracts executed with Providers seek to apply best practices in the management of its Provider Network. The requirements of this section do not prevent the Contractor from including additional terms and conditions in its subcontracts to meet the legal obligations or system requirements of the Contractor. Contractor ensures that the following standards are included in its Subcontracts:

a. General Standards

Contractor shall ensure that all subcontracts are in writing, specify the subcontracted Work and reporting responsibilities, meet the requirements described below and any other requirement as described throughout this Contract, and incorporate portions of this Contract, as applicable, based on the scope of Work to be subcontracted.

- (1) Subject to the provisions of this section, Contractor may subcontract any or all of the Work to be performed under this Contract. No Subcontract may terminate or limit Contractor's legal responsibility to OHA for the timely and effective performance of Contractor's duties and responsibilities under this Contract. Any and all Corrective Action, sanctions, recovery amounts and/or enforcement actions are solely the responsibility of the Contractor.
- (2) The following requirements of this Contract may not be subcontracted:
 - (a) Oversight and monitoring of quality improvement activities; and
 - (b) Adjudication of final Appeals in a Member Grievance and Appeal process.
- (3) Contractor shall negotiate a rate of reimbursement with Fully Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) that is not less than the level and amount of payment which the Contractor would make for the same service(s) furnished by a Provider, which is not a FQHC or RHC consistent with the requirements of 42 USC §1396b (m)(2)(A)(ix) and BBA 4712(b)(2);

- (4) Contractor shall ensure that Subcontractors and Providers do not bill Members for services that are not covered under this Contract unless there is a full written disclosure or waiver on file signed by the Member, in advance of the service being provided, in accordance with OAR 410-141-0420.
- (5) Contractor shall monitor the Subcontractor's performance on an ongoing basis and perform at least once a year a formal review of compliance with delegated responsibilities and Subcontractor performance, deficiencies or areas for improvement, in accordance with 42 CFR 438.230. Upon identification of deficiencies or areas for improvement, Contractor shall cause Subcontractor to take Corrective Action and shall notify the Contract Administrator of the Corrective Action.
- (6) Contractor's agreement with the Subcontractor shall:
 - (a) Provide for the termination of the Subcontract or imposition of other sanctions by Contractor if the Subcontractor's performance is inadequate to meet the requirements of this Contract; and
 - (b) Require Subcontractor to comply with the requirements of 42 CFR 438.6 that are applicable to the Work required under the subcontract; and
- (7) Contractor shall meet, and require its Participating Providers to meet, OHP standards for timely access to care and services, taking into account the urgency of the need for services as specified in OAR 410-141-3220. This requirement includes the Participating Providers offering hours of operation that are not less than the hours of operation offered to Contractor's commercial members (as applicable).

8. Access to Care

Contractor shall provide culturally and linguistically appropriate services and supports, in locations as geographically close to where Members reside or seek services as possible, and choice of Providers within the delivery system network that are, if available, offered in non-traditional settings that are accessible to Families, diverse communities, and underserved populations.

- a. Contractor shall meet, and require Providers to meet, OHP standards for timely access to care and services, taking into account the urgency of need for services. Contractor shall comply with OAR 410-141-3220 and 410-141-3160.
- b. Contractor shall ensure that Providers do not discriminate between Members and non-OHP persons as it relates to benefits and services to which they are both entitled and shall ensure that Providers offer hours of operation to Members that are no less than those offered to non-Members as provided in OAR 410-141-3220.
- c. Contractor shall provide each Member with an opportunity to select an appropriate Mental Health Practitioner and service site.
- d. Contractor may not deny Covered Services to, or request Disenrollment of, a Member based on disruptive or abusive behavior resulting from symptoms of a mental disorder or from another disability. Contractor shall develop an appropriate treatment plan with the Member and the Family or advocate of the Member to manage such behavior.

- e. Contractor shall implement mechanisms to assess each Member with Special Health Care needs in order to identify any ongoing special conditions that require a course of physical health, chemical dependency, or mental health treatment or care management.
 - (1) For Members with Special Health Care Needs determined to need a course of treatment or regular care monitoring, the Individual Service and Support Plan must be developed with Member participation and in consultation with any specialists caring for the Member; approved by Contractor in a timely manner, if approval is required; and developed in accordance with any applicable OHA quality assessment and performance improvement and utilization review standards.
 - (2) Based on the Assessment, Contractor shall assist Members with Special Health Care Needs in gaining direct access to Medically Appropriate care from physical health, chemical dependency or mental health specialists for treatment of the Member's condition and identified needs.
 - (3) Contractor shall implement procedures to share with Member's primary health care provider the results of its identification and Assessment of any Member with Special Health Care Needs so that those activities need not be duplicated. Such coordination and sharing of information must be conducted within Federal and State laws, rules, and regulations governing confidentiality.
- f. Contractor shall comply with the requirements of Title II of the Americans with Disabilities Act and Title VI of the Civil Rights Act by assuring communication and delivery of Covered Services to Members who have difficulty communicating due to a disability, or limited English proficiency or diverse cultural and ethnic backgrounds, and shall maintain written policies, procedures and plans in accordance with the requirements of OAR 410-141-3220.
- g. Contractor shall ensure that its employees, Subcontractors and facilities are prepared to meet the special needs of Members who require accommodations because of a disability or limited English proficiency. Contractor shall include in its Grievance and Appeal procedures, described in Exhibit I, a process for Grievances and Appeals concerning communication or access to Covered Services or facilities.
- h. In addition to access and Continuity of Care standards specified in the rules cited in Subsection a, of this section, Contractor shall establish standards for access to Covered Services and Continuity of Care which are consistent with the Accessibility requirements in OAR 410-141-3220.
- i. Contractor shall ensure that each Member has an ongoing source of primary care appropriate to the Member's needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished as described in OAR 410-141-3120 and required by 42 CFR 438.208 (b)(1).
- j. Contractor shall allow each Native American or Alaska Native enrolled with Contractor to choose an Indian Health Care Provider as the Member's PCP if:
 - (1) An Indian Health Care Provider is participating as a PCP within the Contractor's network; and
 - (2) The Native American or Alaska Native Member is otherwise eligible to receive services from such Indian Health Care Provider; and

- (3) The Indian Health Care Provider has the capacity to provide primary health care services to such Members.
- k.** Contractor shall implement procedures to ensure that in the process of coordinating care, each Member's privacy is protected consistent with the confidentiality requirements in 42 CFR parts 160 and 164.
- l.** Contractor shall provide female Members with direct access to women's health specialists within Contractor's Participating 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.
- m.** Contractor shall provide for a second opinion from a qualified Participating Provider, which may include a qualified mental health Participating Provider if appropriate, to determine Medically Appropriate services. If a qualified Participating Provider cannot be arranged then Contractor shall arrange for the Member to obtain the second opinion from a Non-Participating Provider, at no cost to the Member.

APPLICANT MAY PROPOSE ADDITIONAL LANGUAGE FOR PART 4; SEE APPENDIX B

Exhibit B –Statement of Work - Part 5 – Health Equity and Elimination Health Disparities

APPLICANT MAY PROPOSE LANGUAGE FOR PART 5; SEE APPENDIX B

DRAFT

Exhibit B –Statement of Work - Part 6 – Payment Methodologies That Support the Triple Aim

APPLICANT MAY PROPOSE LANGUAGE FOR PART 6; SEE APPENDIX A

DRAFT

Exhibit B –Statement of Work - Part 7 – Health Information Systems

Contractor shall maintain a health information system that meets the requirements of this Contract, as specified in 42 CFR 438.242 and that will collect, analyze, integrate and report data that can provide information on areas including but not limited to:

- Names and phone numbers of the member’s primary care physician or clinic, primary dentist and mental health practitioner;
- Copies of Client Process Monitoring System (CPMS) enrollment forms;
- Copies of long term psychiatric care determination request forms;
- Evidence that the member has been informed of rights and responsibilities;
- Grievance, appeal and hearing records;
- Utilization of services;
- Disenrollment for other than loss of Medicaid eligibility; and
- Coordinated care services provided to members, though encounter data system or other documentation system.

1. Collect data at a minimum on:

- a.** Provider characteristics as required in Exhibit G;
- b.** Member characteristics, including but not limited to race, ethnicity and preferred language in accordance with OHA and DHS standards;
- c.** Member Enrollment; and
- d.** Services provided to Members for Pharmacy, and encounter data reporting.

2. Ensure Claims data received from Providers, either directly or through a third party submitter, is accurate, truthful and complete in accordance with OAR 410-141-3320 and OAR 410-120-1280 by:

- a.** Verifying accuracy and timeliness of reported data;
- b.** Screening data for completeness, logic and consistency;
- c.** Submitting the certification contained in Exhibit B, Part 8, Section 7;
- d.** Collecting service information in standardized formats to the extent feasible and appropriate, if HIPAA standard Contractor must utilize the HIPAA standard including OHA Electronic Data Transmission (EDT) procedures; and
- e.** Confirming Member’s responsibility for its portion of payment as stated in 42 CFR 438.10

3. Make all collected and reported data available upon request to OHA and CMS (as specified in 42 CFR 438.242).

APPLICANT MAY PROPOSE ADDITIONAL LANGUAGE FOR PART 7; SEE APPENDIX A

DRAFT

Exhibit B –Statement of Work - Part 8 – Operations

1. Accountability and Transparency of Operations

- a. Contractor shall use best practices in the management of finances, contracts, claims processing, payment functions and provider networks consistent with ORS 414.625.
- b. Contractor and its Subcontractors shall provide timely access to records and facilities and cooperate with OHA in collection of information through consumer surveys, on-site reviews, medical chart reviews, financial reporting and financial record reviews, interviews with staff, and other information for the purposes of monitoring compliance with this Contract, including but not limited to verification of services actually provided, and for developing and monitoring performance and outcomes.
- c. Contractor shall assist OHA with development and distribution of survey instruments and participate in other evaluation procedures determined appropriate for evaluating CCO progress on payment reform and delivery system change including the achievement of benchmarks, progress toward eliminating health disparities, results of evaluations, customer satisfaction, use of patient centered primary care homes, the involvement of local governments in governance and service delivery, or other developments as determined necessary by OHA, CMS or external review organizations.
- d. Contractor shall, based on written policies and procedures, develop and maintain a record keeping system that:
 - (1) Includes sufficient detail and clarity to permit internal and external review to validate encounter submissions and to assure Medically Appropriate services are provided consistent with the documented needs of the CCO member; and
 - (2) Conforms to accepted professional practice; and
 - (3) Allows the Contractor to ensure that data received from Providers is accurate and complete by:
 - (a) Verifying the accuracy and timeliness of reported data;
 - (b) Screening the data for completeness, logic, and consistency; and
 - (c) Collecting service information in standardized formats to the extent feasible and appropriate.
- e. Contractor shall ensure that the record keeping systems of its Participating Providers conform to the standards of Paragraph d.
- f. Contractor's failure to submit data, provide access to records or facilities, participate in consumer surveys or other accountability requirements in accordance with this Contract is noncompliance with the terms of this Contract and is grounds for sanction as specified in Exhibit D, Section 31 through 35.

2. Privacy, Security and Retention of Records

- a.** Maintenance and Security: Contractor shall have written policies and procedures that ensure maintenance of a record keeping system that includes maintaining the security of records as required by the Health Insurance Portability and Accountability Act (HIPAA), 42 USC § 1320-d et seq., and the federal regulations implementing the Act, and complete Clinical Records that document the coordinated care services received by the Members. Contractor shall communicate these policies and procedures to Participating Providers, regularly monitor Participating Providers' compliance with these policies and procedures and take any corrective action necessary to ensure Participating Provider compliance. Contractor shall document all monitoring and corrective action activities. Such policies and procedures must ensure that records are secured, safeguarded and stored in accordance with applicable Oregon Revised Statutes (ORS) and Oregon Administrative Rules (OAR).
- b.** Members must have access to the member's personal health information in the manner provided in 45 C.F.R. 164.524 and ORS 179.505(9) so the member can share the information with others involved in the member's care and make better health care and lifestyle choices. Contractor and PHP's Participating Providers may charge the member for reasonable duplication costs when the member seeks copies of their records.
- c.** Notwithstanding ORS 179.505, Contractor, its provider network and programs administered by OHA and DHS may use and disclose member information for purposes of service and care delivery, coordination, service planning, transitional services and reimbursement, in order to improve the safety and quality of care, lower the cost of care and improve the health and well-being of the members.
- d.** Contractor and its provider network may use and disclose sensitive diagnosis information including HIV and other health and mental health diagnoses, within the Contractor for the purpose of providing whole-person care. Individually identifiable health information must be treated as confidential and privileged information subject to ORS 192.553 to 192.581 and applicable federal privacy requirements. Redisclosure of individually identifiable information outside of the Contractor and the Contractor's providers for purposes unrelated to this section or the requirements of ORS 414.625, 414.632, 414.635, 414.638, 414.653 or 414.655 remains subject to any applicable federal or state privacy requirements.
- e.** Contractor and the Contractor's provider network may disclose information about members to the OHA and DHS for the purpose of administering the laws of Oregon.
- f.** Contractor shall document its method and findings to ensure across the organization and the network of providers there is documentation of the following coordinated care services and supports: :

 - (1)** Each member has a consistent and stable relationship with a care team that is responsible for comprehensive care management and service delivery.
 - (2)** The supportive and therapeutic needs of the member is addressed in a holistic fashion, using patient centered primary care homes and individualized care plans to the extent feasible.
 - (3)** Members receive comprehensive transitional care, including appropriate follow-up, when entering and leaving an acute care facility or a long term care setting.
 - (4)** Members receive assistance in navigating the health care delivery system and in accessing community and social support services and statewide resources, including the

use of certified health care interpreters, community health workers and personal health navigators.

- (5) Members have access to advocates, including qualified peer wellness specialists where appropriate, personal health navigators, and qualified community health workers who are part of the member's care team to provide assistance that is culturally and linguistically appropriate to the member's need to access appropriate services and participate in processes affecting the member's care and services.
- (6) Members are encouraged within all aspects of the integrated and coordinated health care delivery system to use wellness and prevention resources and to make healthy lifestyle choices.

g. Access to Records: Contractor shall cooperate with DMAP, AMH, the Department of Justice Medicaid Fraud Unit, and CMS, or other authorized state or federal reviewers, for the purposes of audits, inspection and examination of members' Clinical Records, whether those records are maintained electronically or in physical files. Documentation must be sufficiently complete and accurate to permit evaluation and confirmation that coordinated care services were authorized and provided, referrals made, and outcomes of coordinated care and referrals sufficient to meet professional standards applicable to the Health Care Professional and to meet the requirements for health oversight and outcome reporting in these rules.

h. Retention of Records: Contractor shall retain Clinical Records for seven years after the date of services for which claims are made. If an audit, litigation, research and evaluation, or other action involving the records is started before the end of the seven-year period, Contractor shall retain the Clinical Records until all issues arising out of the action are resolved.

i. Public Records Law

Contractor understands that information prepared, owned, used or retained by OHA is subject to the Public Records Law, ORS 192.410 et. seq.

3. Payment Procedures

- a.** Contractor shall pay for all Covered Services to Members and may require, except in an emergency that Members obtain such Covered Services from Contractor or Providers affiliated with Contractor in accordance with OAR 410-141-0420 Billing and Payment.
- b.** Contractor shall ensure that neither OHA nor the Member receiving services are held liable for any costs or charges related to Contractor-authorized Covered Services rendered to a Member whether in an emergency or otherwise.
- c.** Except as specifically permitted by this Contract including Third Party Resources recovery, Contractor and its Subcontractors may not be compensated for Work performed under this Contract from any other department of the State, nor from any other source including the federal government.
- d.** Contractor shall comply with Section 6507 of the Patient Protection and Affordable Care Act (PPACA) regarding the use of National Correct Coding Initiative (NCCI).

- e. Contractor shall comply with PPACA Section 6402 and the False Claims Act which obligates Contractor to notify OHA of the existence of an overpayment within 60 days of acknowledgement or referral by a third party to OHA.
- f. An objective of this Contract is to promote the effective delivery of Covered Services to individuals who are dually eligible for Medicare and Medicaid. Contractor may receive additional instructions about payment procedures that may be used for services that are covered by both Medicare and Medicaid.
- g. Certain federal laws governing reimbursement of Federally Qualified Health Centers, Rural Health Centers and Indian Health Care Providers may require OHA to provide supplemental payments to those entities, even though those entities have subcontracted with Contractor to provide Covered Services and including Indian Health Care Providers that do not have a subcontract with the Contractor. These supplemental payments are outside the scope of this Contract and do not violate the prohibition on dual payment contained herein. Contractor shall maintain encounter data records and such additional Subcontract information documenting Contractor's reimbursement to Federally Qualified Health Centers, Rural Health Centers and Indian Health Care Providers, and to provide such information to OHA upon request. Contractor shall provide information documenting Contractor's reimbursement to non-participating Indian Health Care Providers to OHA upon request.
- h. Except as specifically permitted by this Contract including Third Party Resources recovery, Contractor and its Subcontractors may not be compensated for Work performed under this Contract from any other department of the State, nor from any other source including the federal government.

4. Claims Payment

- a. Claims that are subject to payment under this Contract by Contractor from Non-Participating Providers who are enrolled with OHA will be billed to Contractor consistent with the requirements of OAR 410-120-1280, 410-120-1295 and 410-120-1300. Contractor shall pay Non-Participating Providers for Covered Services, consistent with the provisions of ORS 414.743, OAR 410-120-1340 and OAR 410-141-3420.
- b. Contractor shall pay Indian Health Care Providers for Covered Services provided to those Native Americans or Alaska Natives enrolled with the Contractor who are eligible to receive services from such providers, as follows:
 - (1) Participating Providers are paid at a rate equal to the rate negotiated between the Contract and the Participating Provider involved, which for a Federally Qualified Health Center (FQHC) may not be less than the level and amount of payment which the Contractor would make for the services if the services were furnished by a Participating Provider which is not a FQHC.
 - (2) Non-Participating Providers that are not a FQHC must be paid at a rate that is not less than the level and amount of payment which the Contractor would make for the services if the services were furnished by a Participating Provider which is not an Indian Health Care Provider.
 - (3) Non-Participating Providers that are a FQHC must be paid at a rate equal to the amount of payment that the Contractor would pay a FQHC that is a Participating Provider with respect to the Contractor but is not an Indian Health Care Provider for such services.

- c. Contractor shall make prompt payment to Indian Health Care Providers that are Participating Providers.
- d. Contractor's shall pay for Emergency Services that are received from non-Participating Providers as specified in OAR 410-141-3140.

5. Medicare Payers and Providers

- a. For those Contractors affiliated with or contracted with an entity that provides services as a Medicare Advantage plan serving Full Dual Eligibles, Contractor shall demonstrate on a yearly basis that Contractor's Provider network is adequate to provide both the Medicare and the Medicaid Covered Services to its Full Dual Eligible population. Contractor shall identify its Providers' Medicaid participation.
- b. Contractor shall assign staff to coordinate with Medicare payers and Providers as Medically Appropriate to coordinate the care and benefits of Members who are eligible for both Medicaid and Medicare.
- c. Contractor is responsible for Medicare deductibles, coinsurance and co-payments up to Medicare's or Contractor's allowable for Covered Services its Medicare eligible Members receive from a Medicare Provider (who is either a Participating Provider, or a Non-Participating Provider) if authorized by Contractor or Contractor's representatives, or for Emergency Services or Urgent Care Services.
- d. Contractor is not responsible for Medicare deductibles, coinsurance and co-payments for skilled nursing facility benefit days 21-100.
- e. Contractors that are affiliated with or contracted with an entity that provides services as a Medicare Advantage plan serving fully Dual eligibles for Medicare and Medicaid may not impose cost-sharing requirements on Dual eligible Members, full benefit fully Dual eligible Members and qualified Medicare beneficiaries that would exceed the amounts permitted by OHP if the Member is not enrolled in the Contractor's Medicare Advantage plan.

6. Eligibility Verification for Dual Eligible Clients

If Contractor is affiliated with or contracted with a Medicare Advantage plan for fully Dual eligibles for Medicare and Medicaid, Contractor shall verify current Member eligibility using the Automated Voice Response system or the MMIS Web Portal.

- a. Pursuant to OAR 410-141-3120, Contractor shall coordinate with Medicare payers and Providers as Medically Appropriate to coordinate the care and benefits of Members who are eligible for both Medicaid and Medicare.
- b. Pursuant to OAR 410-141 0420, Contractor is responsible for Medicare deductibles, coinsurance and co-payments up to Medicare's or Contractor's allowable for Covered Services its Medicare eligible Members receive from a Medicare Provider, who is either a Participating Provider, or a Non-Participating Provider, if authorized by Contractor or Contractor's representatives, or for Emergency Services or Urgent Care Services.

7. Encounter Data

- a. Contractor shall transmit data to OHA using HIPAA Transaction Standards for pharmacy data transactions and health care Claims data as specified in 45 CFR 162.1101 and 162.1102, using the OHA Encounter Data EDI Trading Partner Technical Specification [\(enter link\)](#).
- b. Contractor shall become a trading partner and conduct data transactions in accordance with OHA Electronic Data Transmission Rules; OAR 943-120-0100 through 943-120-0200.
- c. Contractor shall demonstrate to OHA through proof of Encounter Data Certification and Validation that Contractor is able to attest to the accuracy, completeness and truthfulness of information required by OHA, in accordance with 42 CFR 438.604 and 438.606. Contractor shall submit the report forms listed below to OHA as described in each form or report.

Signature Authorization Form, located at: _____@_____.

Encounter Data Certification and Validation Report Form, located at:

_____@_____.

Encounter Claim Count Verification Acknowledgement and Action Form, located at:

_____@_____.

- d. Contractor shall submit Pharmacy Expense Reports as required in the following forms which are hereby incorporated by this reference:

Pharmacy Expense Reports - Report 3.1 – Pharmacy Expense Proprietary Exemption Request Form found at: _____@_____.

Pharmacy Expense Reports - Report 3.2 – Pharmacy Expense Proprietary Exemption Request Form found at: _____@_____.

8. Financial Reporting Related to Paid Claims

- a. Failure by Contractor to comply with the paid claims or encounter data reporting requirements or form G.12 - Financial Reporting Related to Paid Claims Data will result in Corrective Action or such other remedies or sanctions as OHA may impose sanctions under Exhibit D, Section 31 through 35, of the Contract.
- b. When Corrective Action has been initiated by OHA, Contractor may submit documentation to OHA citing specific circumstances which delay Contractor’s timely submittal of the data or information described in Exhibit B, Part 8, Section 8.
- c. OHA will review the documentation and make a determination within 14 calendar days on whether the circumstances cited are acceptable.

9. Third Party Liability and Personal Injury Liens

- a. Contractor shall take all reasonable actions to pursue recovery of Third Party Liability for Covered Services provided during the Contract year. “Third Party Liability” means any individual, entity, or program that is, or may be, liable to pay all or part of the medical cost of any medical assistance furnished to a Member.
- b. Contractor shall develop and implement written policies describing its procedures for Third Party Liability recovery. OHA may review Contractor’s policies and procedures for compliance with this Contract and, to the extent OHA determines applicable, for consistency with Third Party

Liability recovery requirements in 42 USC 1396a(a)(25), 42 CFR 433 Subpart D, OAR 461-195-0301 to 461-195-0350, OAR 410-141-3080 and ORS 416-510 to 416-610.

- c.** Contractor shall maintain records of Contractor's actions and Subcontractors' actions related to Third Party Liability recovery, and make those records available for OHA review.
- d.** Contractor shall report all Third Party Liability to OHA on the OHP Coordination of Benefits and Subrogation Recovery Section on the Quarterly Report, Report G.8 of Exhibit G.
- e.** Contractor shall maintain records of Third Party Liability recovery actions that do not result in recovery, including Contractor's written policy establishing the threshold for determining that it is not cost effective to pursue recovery action.
- f.** Contractor shall provide documentation about personal injury recovery actions and documentation about personal injury liens to OPAR's Personal Injury Liens Unit consistent with OAR 461-195-0301 to 461-195-0350.
- g.** Contractor may not refuse to provide Covered Services, and shall require that its Subcontractors may not refuse to provide Covered Services, to a Member because of a Third Party potential liability for payment for the Covered Service.
- h.** Contractor is the payer of last resort when there is other insurance or Medicare in effect. At OHA's discretion or at the request of the Contractor, OHA may retroactively Disenroll a Member to the time the Member acquired Third Party Liability insurance, pursuant to OAR 410-141-3080(2)(b)(D) or 410-141-3080(3)(a)(A), based on OHA's determination that services may be provided cost effectively on a fee-for-service basis. When a Member is retroactively Disenrolled under this section of this Contract, OHA will recoup all Capitation Payments to Contractor after the effective date of the Disenrollment. Contractor and its Providers may not seek to collect from a Member (or any financially responsible Member Representative) or any Third Party Liability, any amounts paid for any Covered Services provided on or after the date of Disenrollment.
- i.** Contractor shall comply with 42 USC 1395y(b), which gives Medicare the right to recover its benefits from employers and workers' compensation carriers, liability insurers, automobile or no fault insurers, and employer group health plans before any other entity including Contractor or its Subcontractor.
- j.** Where Medicare and Contractor have paid for services, and the amount available from the Third Party Liability is not sufficient to satisfy the Claims of both programs to reimbursement, the Third Party Liability must reimburse Medicare the full amount of its Claim before any other entity, including Contractor or its Subcontractor, may be paid.
- k.** If the Third Party has reimbursed Contractor or its Subcontractor, or if a Member, after receiving payment from the Third Party Liability, has reimbursed Contractor or its Subcontractor, the Contractor or its Subcontractor must reimburse Medicare up to the full amount the Contractor or Subcontractor received, if Medicare is unable to recover its payment from the remainder of the Third Party Liability payment.
- l.** Any such Medicare reimbursements described in this section are the Contractor's responsibility on presentation of appropriate request and supporting documentation from the Medicare carrier. Contractor shall document such Medicare reimbursements in its report to OHA.

- m. When engaging in Third Party Liability recovery actions, Contractor shall comply with, and require its Subcontractors or agents to comply with, federal and State confidentiality requirements, described in Exhibit E of this Contract. OHA considers the disclosure of Member Claims information in connection with Contractor's Third Party Resource recovery actions a purpose that is directly connected with the administration of the Medicaid program.

10. Drug Rebate Program

Contractor shall furnish OHA with information requested by OHA regarding rebates for any covered outpatient drug provided by the Contractor, as follows:

- a. Contractor acknowledges that OHA is eligible for the rebates authorized under Section 1927 of the Social Security Act (42 USC 1396r-8), as amended by section 2501 of the Patient Protection and Affordable Care Act (P.L. 111-148) and section 1206 of the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), for any covered outpatient drug provided by Contractor, unless the drug is subject to discounts under Section 340B of the Public Health Service Act.
- b. Contractor shall report prescription drug data as specified in Exhibit B, Part 8, Section 7 of this Contract, including the national drug code of each covered outpatient drug dispensed to Members.

11. All Payers All Claims (APAC) Reporting Program

- a. Contractor shall participate in the APAC reporting system established in ORS 442.464 and 442.466. Data submitted under this Contract may be used by OHA for purposes related to obligations under ORS 442.464 to 442.468 and OAR 409-025-0100 to OAR 409-025-0170.

This data will be used in conjunction with Section 5 of this exhibit.

12. Prevention/Detection of Fraud and Abuse

a. Fraud and Abuse Policies

Contractor shall have fraud and abuse policies in accordance with 42 CFR 433.116, 42 CFR 438.214, 438.600 to 438.610, 438.808, 42 CFR 455.20, 455.104 through 455.106 and 42 CFR 1002.3, which enable the Contractor or its Subcontractor to prevent and detect fraud and abuse activities as such activities relate to the OHP. These policies must include compliance with all federal and State laws, operational policies and controls in areas such as Claims, prior authorization, service verification, utilization management and quality review, Member Grievance and Appeal resolution, Participating Provider credentialing and contracting, Participating Provider and staff education, and Corrective Action Plans to prevent potential fraud and abuse activities.

Contractor shall include in any employee handbook for the Contractor or its Subcontractor, a specific discussion of the applicable fraud and abuse Federal and State laws, the rights of employees to be protected as whistleblowers, and the Contractor's policies and procedures for detecting and preventing fraud, waste and abuse.

b. Review of Fraud and Abuse Policies

Contractor shall review its fraud and abuse policies annually and submit a written copy to OHA, by May 1st of every year this Contract is in effect. If the Contractor has updated the current policies, Contractor shall submit a written copy of the updated fraud and abuse policies to OHA for approval.

c. Referral Policy

- (1) Contractor shall promptly refer all suspected cases of fraud and abuse, including fraud by its employees and Subcontractors to the Medicaid Fraud Control Unit (MFCU). Contractor may also refer cases of suspected fraud and abuse to the MFCU or to the Department of Human Services Audit Unit prior to verification.
- (2) If Contractor is aware that there are credible allegations of fraud for which an investigation by MFCU is pending against a Provider, Contractor shall suspend payments to the Provider unless OHA determines there is good cause not to suspend payments or to suspend payments in part. If the act does not meet the good cause criteria, the Contractor shall work with the MFCU to determine if any Participating Provider contract should be terminated.
- (3) Fraud and Abuse Referral Characteristics of a Case that should be referred.
 - (a) Examples of fraud and abuse within Contractor's network:
 - (i) Providers who consistently demonstrate a pattern of intentionally reporting encounters or services that did not occur. A pattern would be evident in any case where 20% or more of sampled or audited services are not supported by documentation in the clinical records. This would include any suspected case where it appears that the Provider knowingly or intentionally did not deliver the service or goods billed;
 - (ii) Providers who consistently demonstrate a pattern of intentionally reporting overstated or up coded levels of service. A pattern would be evident by 20% or more of sampled or audited services that are billed at a higher-level procedure code than is documented in the clinical records;
 - (iii) Any suspected case where the Provider intentionally or recklessly billed Contractor more than the usual charge to non-Medicaid recipients or other insurance programs;
 - (iv) Any suspected case where the Provider purposefully altered, falsified, or destroyed clinical record documentation for the purpose of artificially inflating or obscuring his or her compliance rating or collecting Medicaid payments otherwise not due. This includes any deliberate misrepresentation or omission of fact that is material to the determination of benefits payable or services which are covered or should be rendered, including dates of service, charges or reimbursements from other sources, or the identity of the patient or Provider;
 - (v) Providers who intentionally or recklessly make false statements about the credentials of persons rendering care to Members;

- (vi) Primary Care Physicians who intentionally misrepresent medical information to justify referrals to other networks or out-of-network Providers when they are obligated to provide the care themselves;
 - (vii) Providers who intentionally fail to render Medically Appropriate Covered Services that they are obligated to provide to Members under their Subcontracts with the Contractor and under OHP regulations;
 - (viii) Providers who knowingly charge Members for services that are Covered Services or intentionally balance-bill a Member the difference between the total fee-for-service charge and Contractor's payment to the Provider, in violation of OHA rules;
 - (ix) Any suspected case where the Provider intentionally submitted a Claim for payment that already has been paid by OHA or Contractor, or upon which payment has been made by another source without the amount paid by the other source clearly entered on the Claim form, and receipt of payment is known to the Provider; and
 - (x) Any case of theft, embezzlement or misappropriation of Title XIX or Title XXI program money.
- (b) Examples of fraud and abuse in the administration of the OHP program:
- (i) Evidence of corruption in the Enrollment and Disenrollment process, including efforts of State employees or Contractors to skew the risk of unhealthy patients toward or away from one of the Contractors; and
 - (ii) Attempts by any individual, including employees and elected officials of the State, to solicit kickbacks or bribes, such as a bribe or kickback in connection with placing a Member into a carved out program, or for performing any service that the agent or employee is required to provide under the terms of his employment.
- (c) Examples of patient abuse and neglect:
- (i) Any Provider who hits, slaps, kicks, or otherwise physically abuses any patient;
 - (ii) Providers who sexually abuse any patient;
 - (iii) Any Provider who intentionally fails to render Medically Appropriate care, as defined in this Contract, by the OHP Administrative Rules and the standard of care within the community in which the Provider practices. If the Provider fails to render Medically Appropriate care in compliance with the Member's decision to exercise his or her right to refuse Medically Appropriate care, or because the Member exercises his rights under Oregon's Death with Dignity Act or pursuant to advance directives, such failure to treat the member shall not be considered patient abuse or neglect; and

- (iv) Providers, e.g. residential counselors for developmentally disabled or personal care Providers, who deliberately neglect their obligation to provide care or supervision of vulnerable persons who are OHP Members (children, the elderly or developmentally disabled individuals).

d. When to Report Fraud and Abuse

Contractor shall report to the MFCU an incident with any of the referral characteristics listed in Subsection c, of this section. Contractor shall report any other incident found to have characteristics which indicate fraud or abuse which Contractor has verified.

Contractor shall comply with all patient abuse reporting requirements and fully cooperate with the State for purposes of ORS 410.610 et.seq., ORS 419B.010 et.seq., ORS 430.735 et.seq., ORS 433.705 et.seq., ORS 441.630 et.seq., and all applicable Administrative Rules. Contractor shall ensure that all Subcontractors comply with this provision.

e. How to Refer a Case of Provider Fraud or Abuse

The Department of Justice Medicaid Fraud Control Unit (MFCU) phone number is (971) 673-1880, address 1515 SW 5th Avenue, Suite 410, Portland, Oregon 97201, and fax is (971)-673-1890. The Department of Human Services Provider Audit Unit phone number is (503) 378-3500, address 2850 Broadway St. NE, Salem, Oregon 97303, and fax is (503) 378-3437.

f. Obligations to Assist the MFCU and OHA

- (1) Contractor shall permit the MFCU or OHA or both to inspect, evaluate, or audit books, records, documents, files, accounts, and facilities maintained by or on behalf of Contractor or by or on behalf of any Subcontractor, as required to investigate an incident of fraud and abuse.
- (2) Contractor shall cooperate, and requires its Subcontractors to cooperate, with the MFCU and OHA investigator during any investigation of fraud or abuse.
- (3) In the event that Contractor reports suspected fraud, or learns of an MFCU or OHA investigation, Contractor should not notify or otherwise advise its Subcontractors of the investigation. Doing so may compromise the investigation.
- (4) Contractor shall provide copies of reports or other documentation, including those requested from the Subcontractors regarding the suspected fraud at no cost to MFCU or OHA during an investigation.

g. Prevention and Detection of Member Fraud and Abuse

Contractor, if made aware of suspected fraud or abuse by a Member (e.g. a Provider reporting Member fraud and abuse), shall report the incident to the DHS Fraud Unit. Address suspected Member fraud and abuse reports to DHS Fraud Investigation P.O. Box 14150 Salem, Oregon 97309-5027, phone number 1-888-FRAUD01 (888-372-8301), facsimile number 503-373-1525 ATTN: HOTLINE.

13. Abuse Reporting and Protective Services

Contractor shall comply, and shall require its Participating Providers to comply, with all protective services, investigation and reporting requirements described in OAR 943-045-0250 through 943-045-0370 and ORS 430.735 through 430.765.

14. Changes in Ownership

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

- a.** Contractor shall notify OHA at least 90 calendar days prior to any change in ownership and reimburse OHA for all legal fees reasonably incurred by OHA in reviewing the proposed assignment or transfer and in negotiating and drafting appropriate documents.
- b.** Contractor shall provide OHA with full and complete information of each person or corporation with an ownership or control interest (which equals or exceeds 5 percent) in the managed care plan, or any Subcontractor in which Contractor has an ownership interest that equals or exceeds 5 percent, consistent with 42 CFR 455.100 through 42 CFR 455.106, and include the following:
 - (1)** Whether any of the persons named in Section 2 are related to one another as a spouse, parent, child or sibling.
 - (2)** Name any other disclosing entity in which a person named in section 2 also has an ownership or controlling interest.
 - (3)** Any person with an ownership or control interest in a Subcontractor with whom the provider has had business transactions totaling more than \$25,000 during a 12 month period ending on the date of request; and any significant business transactions between provider and wholly-owned supplier or between provider and Subcontractor during a 5 year period ending on the date of request.
 - (4)** Any person who has an ownership or controlling interest in the provider, or is an agent or managing employee of the provider, and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or other federal services program since inception of those programs.
- c.** Contractor shall notify OHA of any changes of address, and as applicable licensure status as a health plan with DCBS or as a Medicare Advantage plan, or Federal Tax Identification Number (TIN), within 14 calendar days of the change.
- d.** Failure to notify OHA of any of the above changes may result in the imposition of a sanction from OHA and may require Corrective Action to correct payment records, as well as any other action required to correctly identify payments to the appropriate TIN.
- e.** Contractor understands and agrees that Contractor is the legal entity obligated under this Contract and that OHA is engaging the expertise, experience, judgment, representations and warranties, and certifications of the Contractor set forth in this Contract and in the Application for this Contract. Contractor may not transfer, Subcontract, reassign or sell its contractual or

ownership interests, such that Contractor is no longer available to provide OHA with its expertise, experience, judgment and representations and certifications, without first obtaining OHA's prior written approval 120 days before such transfer, subcontract, reassignment or sale occurs, except as otherwise provided in Exhibit B, Part 4, Section 2 of this Contract governing adjustments in Service Area or Enrollment, Exhibit D, Section 18 "Subcontracting".

- f.** As a condition precedent to obtaining OHA's approval, Contractor shall provide to OHA all of the following:
- (1)** The name(s) and address(es) of all directors, officers, partners, owners, or persons or entities with beneficial ownership interest of more than 5% of the proposed new Entity's equity; and
 - (2)** Representation and warranty signed and dated by the proposed new Entity and by Contractor that represents and warrants that the policies, procedures and processes issued by the current Contractor will be those policies, procedures, or processes provided to OHA by the current Contractor or by an existing Contractor within the past two years, and that those policies, procedures and processes still accurately describe those used at the time of the ownership change and will continue to be used once OHA has approved the ownership change request, except as modified by ongoing Contract and Administrative Rule requirements. If Contractor and the proposed new Entity cannot provide representations and warranties required under this subsection, OHA shall be provided with the new policies, procedures and processes proposed by the proposed new Entity for review consistent with the requirements of this Contract; and
 - (3)** The financial responsibility and solvency information for the proposed new Entity for OHA review consistent with the requirements of this Contract; and
 - (4)** Contractor's assignment and assumption agreement or such other form of agreement, assigning, transferring, subcontracting or selling its rights and responsibilities under this Contract to the proposed new Entity, including responsibility for all records and reporting, provision of services to Members, payment of valid claims incurred for dates of services in which Contractor has received a Capitation Payment, and such other tasks associated with termination of Contractor's contractual obligations under this Contract.
- g.** OHA may require Contractor to provide such additional information or take such actions as may reasonably be required to assure full compliance with Contract terms as a condition precedent to OHA's agreement to accept the assignment and assumption or other agreement.
- h.** OHA will review the information to determine that the proposed new entity may be certified to perform all of the obligations under this Contract and that the new entity meets the financial solvency requirements and insurance requirements to assume this Contract.

15. Credentialing

- a.** Contractor shall have written policies and procedures for collecting evidence of credentials, screening the credentials, reporting credential information and recredentialing of Participating Providers, programs and facilities used to deliver Covered Services, consistent with PPACA Section 6402, 42 CFR 438.214, 42 CFR 455.400-455.470, OAR 410-141-3120 and Exhibit G, except as provided in Subsection b, of this Section. These procedures shall also include collecting proof of professional liability insurance.

- b.** If Participating Providers (whether employees or Subcontractors) are not required to be licensed or certified by a State of Oregon board or licensing agency, Contractor shall document, certify and report on Exhibit G the date that the person's education, experience, competence, and supervision are adequate to permit the person to perform his or her specific assigned duties.
- (1) If Participating Providers are not required to be licensed or certified by a State of Oregon board or licensing agency, then:
- (a) Participating Providers must meet the definitions for QMHA or QMHP as described in Exhibit A, Definitions and provide services under the supervision of a LMP as defined in Exhibit A, Definitions; or
- (b) For Participating Providers not meeting either the QMHP or QMHA definition, Contractor shall document and certify that the person's education, experience, competence, and supervision are adequate to permit the person to perform his or her specific assigned duties.
- (2) All programs operated directly or by subcontract must be accredited by nationally recognized organizations recognized by the Authority for the services provided (e.g., Council on Accredited Rehabilitation Facilities (CARF), TJC and/or are certified under OAR 309-012-0130 et. seq., or licensed under ORS Chapter 443 by the State of Oregon to deliver specified services including, OAR 309-032-0175 through 309-032-1565.
- (3) Facilities used to deliver mental health services specified in OAR 309-032-0175 through 309-032-1560 and 309-033-0700 through 309-033-0740, must be certified or licensed by the State of Oregon.
- c.** Contractor shall not discriminate with respect to participation, reimbursement or indemnification as to any Provider who is acting within the scope of the Provider's license or certification as specified in 42 CFR 438.12 and under applicable State law, solely on the basis of such license or certification. This paragraph does not prohibit Contractor from including Providers only to the extent necessary to meet the needs of Members or from establishing any measure designed to maintain quality and control costs consistent with Contractor's responsibilities under this Contract. This paragraph does not preclude Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty.
- d.** Contractor shall maintain records documenting academic credentials, training received, licenses or certifications of staff and facilities used, and reports from the National Practitioner Data Bank and must provide accurate and timely information about license or certification expiration and renewal dates to the OHA. Contractor may not refer members to or use providers who do not have a valid license or certification required by state or federal law. If Contractor knows or has reason to know that a provider's license or certification is expired or not renewed or is subject to licensing or certification sanction, the Contractor must immediately notify OHA's Provider Services Unit.
- e.** To support the OHA objective of providing efficient and quality health care to Members, Contractor shall utilize a universal credentialing process for the centralized collection, verification and distribution of all Provider data to be used for credentialing and privileging.
- f.** Contractor may not refer members to or use providers who have been terminated from OHA or excluded as Medicare or Medicaid providers by CMS or who are subject to exclusion for any lawful conviction by a court for which the provider could be excluded under 42 CFR 1001.101.

Contractor may not accept billings for services to members provided after the date of the provider's exclusion, conviction, or termination. If Contractor knows or has reason to know that a provider has been convicted of a felony or misdemeanor related to a crime, or violation of federal or state laws under Medicare, Medicaid, or Title XIX (including a plea of "nolo contendere"), the Contractor must immediately notify OHA's Provider Services Unit.

- g.** Only registered National Provider Identifiers (NPIs) and taxonomy codes reported to the OHA in the Provider Capacity Report may be used for purposes of encounter data submission, prior to submitting encounter data in connection with services by the provider.
- h.** Contractor shall require each Physician and other qualified provider to have a unique provider identification number that complies with 42 USC 1320d-2(b).
- i.** Contractor shall provide training for Contractor staff and Participating Providers and their staff regarding the delivery of covered coordinated care services, applicable administrative rules, and the Contractor's administrative policies.

APPLICANT MAY PROPOSE ADDITIONAL LANGUAGE FOR PART 8

Exhibit B –Statement of Work - Part 9 – Quality Performance Outcomes and Accountability

1. Quality Assessment Performance Improvement Program (QAPI)

Contractor shall have an ongoing QAPI program for the services it furnishes to its Members in accordance with 42 CFR 438.240, which requires the following:

- a. Contractor shall develop and implement a minimum of three performance improvement projects (PIP) that are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical and non-clinical areas that are expected to have favorable effect on health outcomes and Member satisfaction. Contractor shall include the following in its ongoing program of PIPs:
 - (1) Measurement of performance using objective quality indicators, which may include the CCO accountability metrics described above;
 - (2) Implementation of system interventions to achieve improvement;
 - (3) Evaluation of the effectiveness of the interventions including among cultural and linguistically diverse populations;
 - (4) Planning and initiation of activities for increasing or sustaining improvement; and
 - (5) Completion in a reasonable time period as to generally allow information on the success of PIP(s) in the aggregate to produce new information on quality every year;
 - (6) An independent EQRO to validate the quality outcomes and timeliness of access to the services covered under this Contract;
 - (7) Submittal of its performance improvement reports using the OHA approved EQRO reporting format on an annual basis (do we need to state about alignment with Medicare here);
 - (8) Mechanisms to detect both underutilization and over utilization of services; and
 - (9) Mechanisms to assess the quality and appropriateness (including cultural and linguistic appropriateness) of care furnished to Members.
- b. Contractor shall establish a QAPI committee that retains authority and accountability to the executive(s) for the quality assessment and performance improvement of care for its members.
 - (1) The committee membership must include, but is not limited to, the QAPI Coordinator, other health professionals who are representative of the scope of the services delivered, and 25% consumer stakeholder participation, as described in this Contract.
 - (2) Contractor shall develop and submit QAPI Work Plan of every year. The written QAPI Program Workplan is subject to approval by OHA.
 - (3) Contractor shall participate as a member of the State’s QAPI committee if such participation is requested by OHA.

2. Program Requirements

- a. Contractor shall report to OHA Health Promotion and Disease Prevention Activities, national accreditation organization results and HEDIS measures as required by the Department of Consumer and Business Services (DCBS) in OAR 836-053-1000. A copy of the reports may be provided to the OHA Performance Improvement Coordinator concurrent with any submission to DCBS

b. External Quality Review and Improvement

In conformance with 42 CFR 438 Subpart E, Contractor, or its Subcontractors and Providers shall provide access to records and facilities for the purpose of an annual external, independent professional review of the quality outcomes and timeliness of, and access to, Services provided under this Contract. If the External Quality Review Organization (EQRO) identifies an adverse clinical situation in which follow-up is needed to determine whether appropriate care was provided, the EQRO will report the findings to OHA and Contractor. Contractor shall assign a staff person(s) to follow-up with the Subcontractor or Provider, in Core Contract QAPI Committee of the finding(s) and involve the QAPI Committee in the development of the resolution. Contractor shall report the resolution to OHA and the EQRO. If determined by OHA, at the recommendation of the EQRO, Contractor shall develop and comply with a Corrective Action Plan as reviewed and approved by OHA.

c. External Quality Review

Contractor shall provide, based on the EQRO:

- (1) An annual PIP validation;
- (2) An annual performance measurement validation;
- (3) An information system capabilities assessment conducted every two years; and
- (4) A compliance review conducted within the previous 3-year period to determine.

d. Reporting Requirements

In conformance with 42 CFR 438.240 Contractor shall annually report the status of Contractor's QAPI program. Contractor's QAPI program report will consist of information supplied by Contractor. The written submission of self-evaluation for the current calendar year is due annually no later than July 31st. The evaluation of the QAPI program and Member care must include a description of completed and ongoing QAPI activities in clinical and non-clinical areas, and an evaluation of the QAPI program's overall effectiveness. Contractor may submit reports, materials or information that are relevant to Paragraphs (1) and (2) below, that Contractor had already submitted to OHA for QIE or to the EQRO. This evaluation includes, but is not limited to:

- (1) Assessment of Contractor initiated performance improvement projects in clinical and/or non-clinical areas. This includes projects to address access to, timeliness, quality and appropriateness (including cultural and linguistic appropriateness) of care. Such projects may include review of: clinical records, utilization reviews, referrals, co-morbidities, prior authorizations, Emergency Services, out of network utilization, medication review,

Contractor initiated Disenrollments, encounter data management, and access to care and services;

- (2) Assessment of access to, timeliness, quality and appropriateness of care for Members who are aged, blind, disabled or children receiving Child Welfare or Oregon Youth Authority services (or Members with special health care needs), including Contractor review of the Exceptional Needs Care Coordination program, and any adverse events for the Members;
- (3) Results of review of Contractor's utilization review mechanisms to detect both under-utilization and over-utilization of services;
- (4) Analysis of above indicators by member race, ethnicity and preferred language; and
- (5) A report on the process for adoption and dissemination of Contractor's evidenced-based clinical practice guidelines; and the identification of specific adopted guidelines.

APPLICANT MAY PROPOSE ADDITIONAL LANGUAGE FOR PART 9; SEE APPENDIX A

Exhibit B –Statement of Work - Part 10 – Financial Reporting Requirements to Ensure Against Risk of Insolvency

APPLICANT MAY PROPOSE LANGUAGE FOR PART 10; SEE APPENDIX E

DRAFT