# OREGON HEALTH PLAN
# PROVIDER SERVICES CONTRACT

# FULLY CAPITATED HEALTH PLAN
# [CONTRACT #]

# WITH

# [NAME OF ENTITY]

# January 1, 2008

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**OREGON HEALTH PLAN PROVIDER SERVICES CONTRACT**
**FULLY CAPITATED HEALTH PLAN**

This Contract is between the State of Oregon, acting by and through its Department of Human Services ("DHS"), Division of Medical Assistance Programs (DMAP), and

[Contractor Name]
[Contractor Address]

hereinafter referred to as "Contractor".

**RECITALS**

DMAP is responsible for the administration of the Medical Assistance Programs, a program for payment of medical and remedial services provided to eligible Oregonians. The Medical Assistance Programs include Medicaid Services, including the Oregon Health Plan Demonstration, the Children's Health Insurance Program (CHIP) and Family Health Insurance Assistance Program (FHIAP), which is administered by the State Office of Private Health Partnerships. As part of that administration, DMAP desires to contract with Contractor to implement, administer and maintain comprehensive prepaid managed care health services as set forth in this Contract to enable DMAP to comply with the specific federal and State requirements.

In consideration of the foregoing Recitals and the mutual terms and conditions set forth below, DMAP and Contractor agree as follows:

## I. Term and Approval

**A.** This Contract shall become effective on January 1, 2008 or on the date on which all parties have signed and the Contract has been approved for legal sufficiency by the Oregon Department of Justice, whichever is later ("Effective Date"). This Contract shall continue in effect, unless otherwise terminated or extended, through December 31, 2008. Contractor shall not be paid for any Work performed under this Contract prior to its Effective Date or after its expiration or termination. Contract termination shall not extinguish or prejudice DHS' right to enforce this Contract with respect to any default by Contractor that has not been cured.

**B.** This Contract may be renewed or extended. In the case of renewal of this Contract, Contractor shall give DMAP not less than 60 days notice or other mutually agreed upon notice of its intent to renew prior to the renewal date. In order for renewal or extension to be effective, the renewal Contract or extension must be approved in writing for legal sufficiency by the Oregon Department of Justice, if such approval is required by law, and be signed by the parties prior to the expiration of this Contract or any extension thereof. A deliverable due on a date beyond the term of this Contract shall apply under the renewal, extension, or successor Contract in effect on such date.

**C.** Whenever this Contract contains provisions for the reduction, exclusion, increase, reinstatement or other alteration in benefits (including but not limited to changes in accordance with Oregon Laws 2005 Chapter 806 (HB 3108)) as specified in Exhibit B, of this Contract, with associated alternative rates specified in Exhibit C, DMAP will give Contractor a Notice to Proceed with such benefit and rate change at least 30 calendar days prior to the effective date of the benefit and rate change.

## II. Contract in its Entirety

This Contract consists of this document together with and includes the following exhibits, and schedules, which are attached hereto and incorporated into this Contract by this reference:

**Exhibit A:** Definitions
**Exhibit B:** Statement of Work
**Exhibit C:** Consideration
**Exhibit D:** Standard Terms and Conditions
**Exhibit E:** Required Federal Terms and Conditions
**Exhibit F:** Insurance Requirements
**Exhibit G:** Solvency Plan and Financail Reporting
**Exhibit H:** Encounter Data Minimum Data Set Requirements and Corrective Action
**Exhibit I:** Third Party Resources and Personal Injury Liens
**Exhibit J:** Prevention and Detection of Fraud and Abuse
**Exhibit K:** Provider Capacity Report
**Exhibit L:** Member Complaints Appeals Report
**Exhibit M:** Physician Incentive Plan Regulation Guidance
**Exhibit N:** Grievance System
**Schedule 1:** Asthma Care Measure
**Schedule 2:** Performance Improvement Projects (PIP)
**Schedule 3:** Pharmacy Expense Reports
**Schedule 4:** Pharmacy Data Requirements and Corrective Action
**Schedule 5:** MCO Enrollment of Dual Eligible Clients

There are no other Contract documents unless specifically referenced and incorporated in this Contract.

## III. Status of Contractor

**A.** Contractor represents and warrants to DHS that:

**1.** Contractor is an Oregon Corporation;

**2.** Contractor shall perform all required Work as an independent Contractor in accordance with the applicable provisions of ORS Chapters 316, 656 and 657;

**3.** Contractor has the power and authority to enter into and perform this Contract;

**4.** This Contract, when executed and delivered, shall be a valid and binding obligation of Contractor enforceable in accordance with its terms;

**5.** The Work under this Contract shall be performed in a good and workmanlike manner and in accordance with the highest professional standards; and

**6.** Contractor shall at all times during the term of this Contract, be qualified to do business in the State of Oregon, professionally competent and duly licensed, if necessary, to perform this Work.

**B.** Contractor shall not provide prepaid health services on a capitated basis to any persons other than DMAP Members, unless Contractor meets all statutory and regulatory requirements as a Health Care Service Contractor under ORS Chapter 750.005(4).

**C.** Contractor designates _____ as the point of contact pursuant to Exhibit D, Section 21 of this Contract. Contractor shall notify DMAP in writing of any changes to the designated contact.

**D.** The representations, warranties and certifications set forth in this section are in addition to, and not in lieu of, any other representations, warranties and certifications provided.

## IV. Service Area

The Service Area is the geographic area in which DMAP Members or Potential DMAP Members reside and for whom the Contractor is authorized to provide Capitated Services under this Contract. Contractor's designated Service Area is listed in Part V, below.

## V. Enrollment Limits

**A.** Contractor's maximum Enrollment limit by Service Area is:

_____

The maximum Enrollment limit established in this section is expressly subject to such additional Enrollment as may be authorized in Exhibit B, Part III, Section 4, of this Contract; however, such additional authorized Enrollment does not create a new maximum Enrollment limit.

**B.** Contractor's total maximum Enrollment limit for the entire Service Area is _____under this Contract, subject to such additional Enrollment as may be authorized in Exhibit B, Part III, Section 4 of this Contract; however, such additional authorized Enrollment does not create a new total maximum Enrollment limit.

## VI. Contractor Information

Tax Compliance

By execution of this Contract, I, an authorized official of Contractor, swear/affirm, under penalty of perjury as provided in ORS 305.385(6), that to the best of my knowledge Contractor is not in violation of any of the tax laws described in ORS 305.380(4).

ADDITIONAL CERTIFICATION

By execution of this Contract, I, an authorized official of Contractor certify that all data, Claims submissions or other submissions that provide a basis for Capitation Payments are true, accurate and complete; and acknowledge that payment of Claims and Capitation Payments will be from Federal and

State funds, and that therefore any falsification, or concealment of a material fact when submitting Claims or other submissions to obtain payments, may be prosecuted under Federal and State laws.

_____
_____

STATE TAX I.D. #: _____

## VII. Interpretation and Administration of Contract

**A.** DMAP has adopted reasonable and lawful policies, procedures, rules and interpretations to promote orderly and efficient administration of this Contract. Contractor shall abide by all laws and Oregon Administrative Rules (OARs) applicable to Contractor's performance under this Contract.

**B.** In interpreting this Contract, its terms and conditions shall be construed as much as possible to be complementary, giving preference to this Contract (without exhibits, schedules or attachments) over any exhibits schedules or attachments. In the event of any conflict between the terms and conditions of Exhibit C, Attachment 2, and any other exhibit, schedule or attachment, Exhibit C, Attachment 2, shall control. In the event of any conflict between the terms and conditions in any other exhibits, schedules or attachments, the document earlier in the Table of Contents shall control. In the event that DMAP needs to look outside of this Contract, including its exhibits, schedules and attachments, for purposes of interpreting its terms, DMAP will consider only the following sources in the order of precedence listed:

**1.** The Grant Award Letters from the Centers for Medicare and Medicaid Services (CMS) for operation of the Oregon Reform Demonstration (Oregon Health Plan Medicaid Demonstration Project) and the Health Insurance Flexibility and Accountability (HIFA) demonstration, including all special terms and conditions and waivers.

**2.** The Federal Medicaid Act, Title XIX of the Social Security Act, and its implementing regulations, except as waived by CMS for the Oregon Health Plan Medicaid Demonstration Project and the HIFA demonstration.

**3.** The Children's Health Insurance Program (CHIP) established by Title XXI of the Social Security Act as amended and as administered in Oregon by DHS.

**4.** The Oregon Revised Statutes (ORS) concerning the Oregon Health Plan.

**5.** The Oregon Administrative Rules (OAR) promulgated by DMAP to implement the Oregon Health Plan program.

**6.** Other applicable Oregon statutes and OARs concerning the Medical Assistance Program.

**C.** If Contractor believes that any provision of this Contract, or DMAP's interpretation hereof, is in conflict with federal or state statutes or regulations, Contractor shall notify OMAP in writing immediately.

**D.** Except as otherwise expressly provided in this Contract, Contractor shall have a right to a review of any DMAP actions or decisions concerning the Contractor's responsibilities under this Contract by requesting Administrative Review as provided in OAR 410-120-1580(4)-(5).

**E.** The representations, warranties and certifications set forth in this section are in addition to, and not in lieu of, any other representations, warranties and certifications provided.

## VIII. Government Status

Contractor certifies that it is not currently employed by the federal government to provide the Work covered by this Contract. Contractor certifies that Contractor is not an employee of the State of Oregon or of any government agency that participates in the Oregon Public Employees' Retirement System.

## IX. Signatures

**CONTRACTOR**

By _____ _____
Authorized Date

Title _____

**DIVISION OF MEDICAL ASSISTANCE PROGRAMS**
500 Summer St., N.E.
Salem, Oregon 97301

By _____ _____
DMAP Deputy Director Date

Reviewed by DMAP Policy and Planning:

By _____ _____
Assistant Section Manager Date

Reviewed by DHS Contracts Coordinator:

By _____ _____
DMAP Contract Administrator Date

**Approved as to Legal Sufficiency:**

By _____ _____
Theodore C. Falk, Senior Assistant Attorney General Date

## EXHIBIT A - Definitions

In addition to any terms that may be defined elsewhere in this Agreement and with the following exceptions and additions, the terms in this Agreement have the same meaning as those terms appearing in Oregon Administrative Rules (OARs) 410-120-0000, 410-141-0000 and 410-120-1160. The order of preference for interpreting conflicting definitions is this Agreement, (following the order of precedence in Section VII), Oregon Health Plan Rules of DHS and General Rules of DHS. The following terms shall have the following meanings when capitalized:

**1.** **"Action,"** when capitalized, means in the case of Contractor, (1) the denial or limited authorization of a requested Covered Service, including the type or level of service, (2) the reduction, suspension or termination of a previously authorized service, (3) the denial in whole or in part, of payment for a service, (4) failure to provide services in a timely manner, (5) the failure of Contractor to act within the timeframes provided in 42 CFR 438.408(b), or (6) for a DMAP Member who resides in a rural Service Area where Contractor is the only Fully Capitated Health Plan (FCHP), the denial of a request to obtain Covered Services outside of Contractor's Participating Provider panel pursuant to OAR 410-141-0160 and 410-141-0220.

**2.** **"Appeal,"** when capitalized, means a request by a DMAP Member or Representative, or by a Provider acting on behalf of the DMAP Member with the Member's written consent, for Contractor to review an Action as defined in this section.

**3.** **"Benefit Group"** means the people listed on the OHP application form and determined to be eligible to receive Covered Services available through the Funded Benefit Package.

**4.** **"Business Day"** means any day except Saturday, Sunday or a legal holiday. The word "day" not qualified as Business Day means calendar day.

**5.** **"Capitated Payment" or "Capitation Payment"** means a monthly prepayment to Contractor for the provision of Capitated Services provided on behalf of DMAP Members. Payment is made on a per DMAP Member, per month basis.

**6.** **"Capitated Services"** means those Covered Services that Contractor agrees to provide in the Statement of Work, Exhibit B, Part I through VI of this Contract, in exchange for a Capitation Payment.

**7.** **"CFR"** means Code of Federal Regulations.

**8.** **"Claim"** means (1) a bill for services, (2) a line item of a service, or (3) all services for one recipient within a bill.

**9.** **"Complaint"** is a DMAP Member's or Representative's expression of dissatisfaction to Contractor or to a Participating Provider about any matter other than an Action, as "Action" is defined in this section.

**10.** **"CMS"** means Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services.

**11.** **"Contract Year"** means this Contract term beginning on the Contract Effective Date and ending on December 31, 2008. If this Contract is renewed or extended, separate Contract years begin on January 1 and ends on the following December 31, unless this Contract expires or is otherwise terminated.

**12.** **"Contractor"** means the entity identified on page 1 of this Contract as "Contractor" and includes any officers, employees, agents and representatives of the Contractor.

**13.** **"Corrective Action" or "Corrective Action Plan"** means a DMAP initiated request for Contractor to develop and implement a time specific plan, that is acceptable to DMAP, for the correction of DMAP identified areas of noncompliance, as described in Exhibit H, Encounter Data Minimum Data Set Requirements and Corrective Action, Schedule 4, Pharmacy Data Requirements and Corrective Action, and in Exhibit B, Part VI, Section 2, Sanctions.

**14.** **"Covered Services"** are Medically Appropriate health services that are funded by the Legislature and described in: ORS 414.705 to 414.750; OAR 410-120-1210, Medical Assistance Benefit Packages and Delivery System; OAR 410-141-0120, Oregon Health Plan Prepaid Health Plan Provision of Health Care Services; OAR 410-141-0520, Prioritized List of Health Services; and OAR 410-141-0480, Oregon Health Plan Plus and Standard Benefit Package of Covered Services; except as excluded or limited under OAR 410-141-0500, Excluded Services and Limitations for OHP Clients.

**15.** **"Department of Human Services" or "DHS"** means the Department of Human Services established in ORS Chapter 409, including such divisions, programs and offices as may be established therein. Wherever the former Office of Medical Assistance Programs or OMAP is used in this Contract of in rule, it shall mean the Division of Medical Assistance Programs or DMAP. Wherever the former Office of Mental Health and Addiction Services (OMHAS) is used in this Contract or in rule, it shall mean the Addictions and Mental Health Division (AMH). Where the former Seniors and People with Disabilities (SPD) is used in this Contract or in rule, it shall mean the Seniors and People with Disabilities Division (SPD). Where the former Children, Adults and Families (CAF) is used in this Contract or rule, it shall mean the Children, Adults and Families Division (CAF). Where the former Health Division is used in this Contract or rule, it shall mean the Public Health Division (PHD).

**16.** **"DMAP Member"** means an OHP Client enrolled with Contractor.

**17.** **"Disenrollment"** means the act of discharging a DMAP Member from Contractor's responsibility under this Contract. After the effective date of Disenrollment an OHP Client is no longer required to obtain Capitated Services from Contractor, nor be referred by Contractor for Medical Case Managed Services.

**18.** **"Employer-Sponsored Insurance"** (ESI) means an employer sponsored health benefit plan in which the employer contribution is in accordance with ORS 735.724(5), and the health benefit plan meets the applicable eligibility criteria of OAR 442-004-0050(2)(f).

**19.** **"Funded Benefit Package"** means the condition/treatment pairs that are above the funding line on the Prioritized List of Health Services as approved by the Oregon Legislature.

**20.** **"Grievance System"** refers to the overall system that includes Complaints and Appeals handled at the Contractor level and access to the State fair hearing process. (Possible subjects for Grievances include, but are not limited to, the quality of care or services provided and aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the DMAP Member's rights.)

**21.** **"Health Care Professionals"** means persons with current and appropriate licensure, certification, or accreditation in a medical, mental health or dental profession, which include but are not limited to: medical doctors (including psychiatrists), dentists, osteopathic physicians, psychologists, registered nurses, nurse practitioners, licensed practical nurses, certified medical assistants, licensed physician assistants, qualified mental health professionals (QMHPs), qualified mental health associates (QMHAs),

dental hygienists, denturists, and certified dental assistants. These professionals may conduct health, mental health or dental assessments of DMAP Members and provide screening services to OHP Clients within their scope of practice, licensure or certification.

**22.** **"Health Information System"** is an interconnected set of information resources under the same direct management control that shares common functionality. The "system" may or may not be computerized, but does include trained personnel to ensure Contract compliance.

**23.** **"Inpatient"** means a hospital patient who is not an Outpatient.

**24.** **"Inpatient Hospital Services"** means services that are furnished in a hospital for the care and treatment of an Inpatient.

**25.** **"Material Change"** for purposes of the reporting required in Exhibit K means any circumstance in which Contractor experiences a change in operations that is reasonably likely to affect Contractor's Participating Provider capacity or reduce or expand the amount, scope or duration of Covered Services being provided to DMAP Members including but not limited to:

**a.** Changes in Contractor's service delivery system that may directly impact the provision of services to Contractor's DMAP Members or affect Provider participation;

**b.** Expansion or reduction of a Service Area requiring a Contract amendment, particularly related to Provider capacity and service delivery in the affected Service Area;

**c.** Modifications of Provider payment processes or mechanisms that could affect Provider participation levels;

**d.** Enrollment of a new population (e.g., roll over or new OHP benefit package recipients);

**e.** Loss of a Participating Provider, specialty Provider, clinic or hospital, previously identified on the Provider Capacity Report that will impact Contractor's OMAP Members; or

**f.** The addition of a Participating Provider, specialty Provider, clinic or hospital not previously identified on the Provider Capacity Report that will impact Contractor's DMAP Members.

**26.** **"Medically Appropriate"** are services and medical supplies that are required for prevention, diagnosis or treatment of a health condition that encompasses physical or mental conditions, or injuries and which are:

**a.** Consistent with the symptoms of a health condition or treatment of a health condition;

**b.** Appropriate with regard to standards of good health practice and generally recognized by the relevant scientific community and professional standards of care as effective;

**c.** Not solely for the convenience of a DMAP Member or a Provider of the service or medical supplies; and

**d.** The most cost effective of the alternative levels of medical services or medical supplies that can be safely provided to a DMAP Member in Contractor's judgment.

**27.** **"Medicare Advantage"** is a capitated health plan that contracts with CMS to provide Medicare benefits to Medicare enrollees.

**28.** **National Provider Identifier (NPI):** is a federally directed Provider number mandated for use on HIPAA covered transactions; individuals, Provider Organization and Subparts of Provider Organizations that meet the definition of health care Provider (45 CFR 160.103) and who conduct HIPAA covered transactions electronically are eligible to apply for an NPI; Medicare covered entities are required to apply for an NPI.

**29.** **"Non-Participating Provider"** means a Provider who does not have a subcontract with Contractor. If a Non-Participating Provider is, or becomes enrolled with DMAP, reimbursement of the Non-Participating Provider is governed by DMAP General Rules (Division 120).

**30.** **"Oregon Health Plan"** (OHP) means the Medicaid Demonstration Project, which expands Medicaid eligibility to eligible OHP Clients. The OHP relies substantially upon prioritization of health services and managed care to achieve the public policy objectives of access, cost containment, efficacy and cost effectiveness in the allocation of health resources.

**31.** **"OHP Client"** means an individual found eligible by DHS to receive services under the OHP.

**32.** **"OHP Plus Benefit Package" or "Plus Benefit Package"** means a benefit package available to eligible OHP Clients as described in OAR 410-120-1210 Medical Assistance Benefits: Excluded Services and Limitations and in OAR 410-141-0520 Prioritized List of Health Services and OAR 410-120-1230.

**33.** **"OHP Standard Benefit Package" or "Standard Benefit Package"** means a benefit package available to eligible OHP Clients (including families, adults and couples) who are not otherwise eligible for the OHP Plus Benefit Package as described in OAR 410-120-1210, Medical Assistance Benefit Packages and Delivery System and in OAR 410-141-0520, Prioritized List of Health Services.

**34.** **"Outpatient"** means a hospital patient who:

**a.** Is treated and released the same day or is admitted to the hospital and discharged before midnight and is not listed on the following day's census, excluding a patient who:

**(1)** Is admitted and transferred to another acute care hospital on the same day;

**(2)** Expires on the day of admission; or

**(3)** Is born in the hospital;

**b.** Is admitted for ambulatory surgery, to a birthing center, a treatment or observation room, or a short-term stay bed;

**c.** Receives observation services provided by a hospital, including the use of a bed and periodic monitoring by hospital nursing or other staff for the purpose of evaluation of a patient's medical condition for a maximum of 48 hours; or

**d.** Receives routine preparation services and recovery for diagnostic services provided in a hospital Outpatient department.

**35.** **"Outpatient Hospital Services"** means services that are furnished in a hospital for the care and treatment of an Outpatient.

**36.** **"Participating Provider"** means an individual, facility, corporate entity, or other organization that supplies medical, dental, or mental health services or medical and dental items and that has agreed to provide those services or items to DMAP Members under a subcontract with Contractor and to bill in accordance with the subcontract with Contractor.

**37.** **"Potential DMAP Member"** is an OHP Client who is subject to mandatory enrollment or may voluntarily elect to enroll in a managed care program, but is not yet enrolled with a specific PHP.

**38.** **"Prepaid Health Plan" or "PHP"** means a managed health, dental, chemical dependency, or mental health care organization that contracts with DMAP and/or AMH on a case managed, prepaid, capitated basis under the OHP. PHPs may be Dental Care Organizations (DCOs), Fully Capitated Health Plans (FCHPs), Mental Health Organizations (MHOs), Physician Care Organizations (PCOs), or Chemical Dependency Organizations (CDOs).

**39.** **"Provider"** means a Participating Provider or a Non-Participating Provider.

**40.** **Provider Taxonomy Codes:** is a standard administrative code set, as defined under HIPPA in Federal regulations at 45 CFR 162, for identifying the Provider type and area of specialization for all health care Providers.

**41.** **"Representative"** means a person who can make OHP related decisions for OHP Clients who are not able to make such decisions themselves. A Representative may be, in the following order of priority, a person who is the OHP Client's health care Representative under ORS 127.505(12), a court-appointed guardian, a spouse, or other family member as designated by the OHP Client, the Individual Service Plan Team (for developmentally disabled clients), a DHS case manager or other DHS designee.

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

**43.** **"Subcontractor"** means any Participating Provider or any other individual, entity, facility, or organization that has entered into a subcontract with the Contractor or any Subcontractor for any portion of the Work under this Contract.

**44.** **"Valid Claim"** means a Claim received by the Contractor for payment of Covered Services rendered to a DMAP Client which: (1) Can be processed without obtaining additional information from the Provider of the service or from a third party; and (2) Has been received within the time limitations prescribed in OHP Rules. A "Valid Claim" does not include a Claim from a Provider who is under investigation for fraud or abuse, or a Claim under review for Medical Appropriateness. A "Valid Claim" is a "clean claim" as defined in 42 CFR 447.45 (b).

**45.** **"Work"** means all components of Contractor's obligations under this Contract, including the administration of Capitated Services, all information, data, reports, and all other materials. "Work" includes all related legal rights and obligations, as more specifically described in the Statement of Work and elsewhere in this Contract.

## EXHIBIT B –Statement of Work

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

# EXHIBIT B –Statement of Work – Part I - Benefits

## 1. Capitated Services

**a.** Contractor shall provide Capitated Services, in exchange for a Capitation Payment.

**b.** Contractor shall have no responsibility under this Contract to provide Medical Assistance Services for DMAP Members unless such services are Capitated Services that are Covered Services.

**c.** Medical Assistance Services that are not Capitated Services are authorized and paid outside of this Contract according to procedures provided in the General Rules and DMAP Provider Guides, or by separate Contract, and are not included in the Capitation Payment. 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 treatment services;

**(5)** Medical assistance services that are Covered Services under the Mental Health Organization Contract;

**(6)** Dental services that are Covered Services under the Dental Care Organization Contract; and

**(7)** Standard therapeutic Class 7 & 11 Prescription drugs, Depakote, Lamictal and their generic equivalents dispensed through a licensed pharmacy. These medications are paid through DMAP's Fee For Service system.

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

**a.** Subject to the provisions of this Contract, Contractor shall pay for Covered Services to DMAP Members eligible for the OHP Plus Benefit Package.

**(1)** Contractor shall provide the OHP Plus Benefit Package of Covered Services, OAR 410-141-0480, 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 410-141-0520.

**(3)** For mental health condition/treatment pairs that appear on the funded portion of the Prioritized List, Contractor is only responsible for the physician-outpatient somatic mental health services and outpatient hospital-somatic mental health services, except to the extent that Contractor has a separate contract with DHS as a Mental Health Organization.

**(4)** Except as otherwise provided in OAR 410-141-0480(7), Contractor is not responsible for excluded or limited services as defined in OAR 410-141-0500.

**(5)** Before denying treatment for a condition that is below the funding line on the Prioritized List for any DMAP Member, especially a DMAP Member with a disability or co-morbid condition, Contractor must determine whether the DMAP Member has a funded condition and paired treatment that would entitle the DMAP Member to treatment under OAR 410-141-0480(7).

**(6)** Contractor is required to notify DMAP'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.

**b.** Subject to the provisions of this Contract, Contractor shall pay for Covered Services to DMAP Members eligible for the OHP Standard Benefit Package.

**(1)** Contractor shall provide the OHP Benefit Package of Covered Services, OAR 410-141-0480 and Medical Assistance Benefit Packages and Delivery System, 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 410-141-0520.

**(3)** For mental health condition/treatment pairs that appear on the funded portion of the Prioritized List, Contractor is only responsible for the physician-outpatient somatic mental health services and outpatient hospital-somatic mental health services, except to the extent that Contractor has a separate contract with DHS as a Mental Health Organization.

**(4)** Except as otherwise provided in OAR 410-141-0480(7), Contractor is not responsible for excluded or limited services as defined in OAR 410-141-0500.

**(5)** Before denying treatment for a condition that is below the funding line on the Prioritized List for any DMAP Member, especially a DMAP Member with a disability or comorbid condition, Contractor must determine whether the DMAP Member has a funded condition and paired treatment that would entitle the DMAP Member to treatment under OAR 410-141-0480(7).

**(6)** Contractor is required to notify DMAP'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.

**c.** Pursuant to ORS 414.720 and 414.735, the Prioritized List of condition-treatment pairs developed by the Health Services Commission may be expanded, limited or otherwise changed, or the funding line for the services on the Prioritized List may be changed by the Legislature.

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

**(2)** Before instituting reductions, DHS is required to obtain the approval of the Legislative Assembly or the Emergency Board if the Legislative Assembly is not in session. In addition, the DHS will notify Contractor at least two weeks prior to any legislative consideration of such reductions.

**(3)** Any reductions made under ORS 414.735 shall take effect no sooner than 60 days following final legislative action approving the reductions. Any reductions shall be made by amendment to this Contract.

**d.** Contractor's utilization management activities must not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Appropriate services to a DMAP Member.

## 3. Authorization of Covered Services

**a.** Contractor may require DMAP Members and Subcontractors to obtain authorization for Covered Services from Contractor, except to the extent prior authorization is not required in OAR 410-141-0420 or elsewhere in this Statement of Work. Contractor shall have written procedures that Contractor follows, and shall require its Participating Providers and Subcontractors to follow, for processing initial and continuing pre-authorization requests received from any Provider, pursuant to OAR 410-141-0420 and in accordance with 42 CFR 438.210(d). Contractor shall have in effect mechanisms to ensure consistent application of review criteria for authorization decisions, taking into account applicable clinical practice guidelines, and shall consult with the requesting Provider when appropriate.

**b.** When the DMAP Member is out of Contractor's Service Area, Contractor may refuse to pay for Covered Services that have not been authorized by Contractor, except for Emergency Services, described in Exhibit B, Part I, Section 5, , and full term childbirth delivery services.

**c.** Contractor shall be responsible for payment of Covered Services provided by a Non-Participating Provider under the following circumstances:

**(1)** Contractor pre-authorized the services pursuant to OAR 410-141-0420(6)(a);

**(2)** Contractor is responsible for payment pursuant to OAR 410-141-0420(6)(e); or

**(3)** Services are Emergency Services, or full term childbirth delivery services.

**d.** Contractor shall 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 shall be documented in the clinical record.

**e.** Contractor shall ensure the provision of sexual abuse exams without prior authorization.

**f.** Contractor shall coordinate preauthorization and related services with Dental Contractor Organizations (DCOs) to ensure the provision of dental care with mutual DMAP Members that is required to be performed in an Outpatient hospital or ambulatory surgical setting due to the age, disability, or medical condition of the DMAP Member.

**(1)** Except as provided in Paragraph (2) of this Subsection f, 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 DMAP Member, who is a patient of the professional, for the following:

**(a)** For the DMAP 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;

**(b)** Any information the DMAP Member needs in order to decide among relevant treatment options;

**(c)** The risks, benefits, and consequences of treatment or non-treatment; and

**(d)** The DMAP 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.

**(2)** Contractor is not required to provide, reimburse for, or provide coverage of a counseling or referral service because of the requirement in Paragraph (1) of this Subsection f. 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:

**(a)** To DMAP:

**(i)** With Contractor's application for a Medicaid contract; and

**(ii)** 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

**(b)** Following DMAP prior approval:

**(i)** To Potential DMAP Members before and during Enrollment; and

**(ii)** To DMAP Members within 90 days after adopting the policy with respect to any particular service.

**g.** As an alternative to Inpatient hospital detoxification, Contractor shall where Medically Appropriate provide medically monitored detoxification in a non-hospital based facility. Admissions for DMAP Members to this level of care shall be consistent with Level III, 7-D of

the American Society of Addiction Medicine (ASAM) Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition-Revised (PPC-2R). Facilities or programs providing medically monitored detoxification services shall be accredited by a nationally recognized organization (e.g., Council on Accredited Rehabilitation Facilities or Joint Commission on Accreditation of Healthcare Organizations) and have a Letter of Approval or license from DHS.

**h.** Contractor must provide to DMAP 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 410-141-0520 and as identified, defined and specified in the OHP Administrative Rules. Contractor must 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 must also ensure the Covered Services are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished.

**i.** Contractor must 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. Contractor must notify the DMAP 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 N.

**j.** 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.

**k.** Contractor must define service authorization in a manner that at least includes an enrolled DMAP Member's request for the provision of a service.

**l.** Contractor shall have written procedures that Contractor follows, and shall require Participating Providers to follow, for the initial and continuing authorizations of services requiring 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 DMAP Member’s condition or disease.

## 4. Covered Service Detail

**a.** Without limiting the generality of Contractor’s obligation to provide Covered Services, when providing Covered Services Contractor shall comply with the specific requirements described in more detail below.

**b.** Contractor may cover, for DMAP Members, services that are in addition to Covered Services.

**c.** Contractor must provide Medically Appropriate Covered Services for any DMAP Member using a Non-Participating Provider when the same services are not available by Contractor’s Participating Provider. Contractor must adequately and timely provide these services out of network for the DMAP Member for as long as Contractor is unable to provide them with a Participating Provider. Contractor must ensure that the cost to the DMAP Member is no greater than it would be if a Participating Provider furnished the services. Non-Participating Providers must coordinate with Contractor with respect to payment, pursuant to OAR 410-120-1295.

**d.** Contractor must meet and require Contractor's 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 410-141-0220. 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).

## 5. Emergency and Urgent Care Services

**a.** Contractor shall have written policies and procedures and monitoring systems that provide for Emergency and Urgent Services for all DMAP Members on a 24-hour, 7-day-a-week basis consistent with OAR 410-141-0140, OHP Prepaid Health Plan Emergency and Urgent Care Medical Services.

**(1)** **"Emergency Services"** are defined as the Covered Services furnished by a Provider that is qualified to furnish these services and that are needed to evaluate or stabilize an Emergency Medical Condition. "Emergency Services" include all Inpatient and Outpatient treatment that may be necessary to assure within reasonable medical probability, that no material deterioration of the patient's condition is likely to result from, or occur during, discharge of the DMAP Member or transfer of the DMAP Member to another facility.

**(2)** **"Emergency Medical Condition"** means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part. An "Emergency Medical Condition" is determined based on the presenting symptoms (not the final diagnosis) as perceived by a prudent layperson (rather than a Health Care Professional) and includes cases in which the absence of immediate medical attention would not in fact have had the adverse results described in the previous sentence.

**(3)** **"Urgent Care Services"** are defined as Covered Services that are Medically Appropriate and immediately required in order to prevent a serious deterioration of a DMAP Member's health that results from an unforeseen illness or an injury. Services that can be foreseen by the individual are not considered Urgent Services.

**(4)** **"Stabilize"** means that no material deterioration of the Emergency Medical Condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility.

**(5)** **"Post Stabilization Services"** means Covered Services related to an Emergency Medical Condition that are provided after a DMAP Member is Stabilized in order to maintain the Stabilized condition or that are provided under the circumstances described in Exhibit B, Part I, Section 5, Subsection h. Paragraph (3) to improve or resolve the DMAP Member's condition.

**b.** Contractor shall not require prior authorization for Emergency Services. Contractor shall provide an after-hours call-in system adequate to triage Urgent Care and Emergency Service calls, consistent with OAR 410-141-0140.

**c.** Contractor must cover and pay for Emergency Services regardless of whether the Provider that furnishes the services has a contract with Contractor and may not deny payment for treatment obtained under either of the following circumstances:

**(1)** A DMAP Member had an Emergency Medical Condition; or

**(2)** A representative of the Contractor instructed the DMAP Member to seek Emergency Services.

**d.** If the Emergency Services Provider does not have a contract with Contractor, Contractor shall pay the Non-Participating Provider pursuant to the Non-Participating Provider rule, 410-120-1295 and General Rules OAR 410-120-1280, Billing, and OAR 410-120-1300, Timely Submission of Claims.

**e.** Contractor shall not:

**(1)** Limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms; or

**(2)** Refuse to cover Emergency Services based on the emergency room Provider, hospital, or fiscal agent not notifying the DMAP Member's PCP or the Contractor of the DMAP Member's screening and treatment within 10 days of presentation for Emergency Services.

**f.** A DMAP Member who has an Emergency Medical Condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

**g.** The attending emergency physician, or the Provider actually treating the DMAP Member, is responsible for determining when the DMAP Member is sufficiently Stabilized for transfer or discharge, and that determination is binding on Contractor for payment purposes.

**h.** Contractor is financially responsible for Post-Stabilization Services obtained by DMAP Members within or outside the Contractor's network under the following circumstances:

**(1)** Post Stabilization Services have been authorized by Contractor's authorized representative;

**(2)** Post Stabilization Services have not been authorized by Contractor's authorized representative, but are administered to maintain the DMAP Member's stabilized condition within 1 hour of a request to the Contractor's authorized representative for approval of further Post Stabilization Services;

**(3)** Post Stabilization Services have not been authorized by Contractor's authorized representative, but are administered to maintain, improve, or resolve the DMAP Member's stabilized condition if:

**(a)** The Contractor's authorized representative does not respond to a request for authorization within 1 hour;

**(b)** The Contractor's authorized representative cannot be contacted; or

**(c)** The Contractor's authorized representative and the treating physician cannot reach an agreement concerning the DMAP Member's care and the Participating Provider is not available for consultation. In this situation, the Contractor must give the treating physician the opportunity to consult with the Participating Provider and the treating physician may continue with care of the DMAP Member until the Participating Provider is reached or one of the criteria in Subsection i below, have been met; or

**(4)** Contractor shall limit charges to DMAP Members, for post stabilization services, to an amount no greater than what the Contractor would charge for in network services.

**i.** Contractor's financial responsibility for Post-Stabilization Services it has not approved ends when:

**(1)** The Participating Provider with privileges at the treating hospital assumes responsibilities for the DMAP Member's care;

**(2)** The Participating Provider assumes responsibility for the DMAP Member's care through transfer;

**(3)** A Contractor representative and the treating physician reach an agreement concerning the DMAP Member's care; or

**(4)** The DMAP Member is discharged.

**6. Emergency Ambulance Transportation**

**a.** Contractor is required to pay for emergency ambulance transportation for DMAP Members including ambulance services dispatched through 911, in accordance with the Emergency Services prudent layperson standard described in the above Section 5, Emergency and Urgent Care Services. Contractor shall make coverage decisions for emergency ambulance services based on the actual services provided.

**b.** 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 410-136-0000, and OAR 410-136-0160, Non-Emergency Medical Transportation.

**7. Medical Case Management**

**a.** Contractor shall provide Medical Case Management Services as described in OAR 410-141-0160, OHP Prepaid Health Plan Continuity of Care. Medical Case Management Services include a comprehensive, ongoing assessment of medical and/or dental needs plus the development and implementation of a plan to obtain needed medical or dental services that are Capitated Services or non-capitated services, and follow up, as appropriate to assess the impact of care.

**b.** Contractor shall coordinate and manage all Capitated Services. Contractor shall document all referrals by Contractor or its Subcontractors to other Non-Participating Providers, whether or not the services are Capitated Services. (Exceptional Needs Care Coordination described in Section

8 below, for aged, blind and disabled DMAP Members described in OAR 410-141-0405 is a service that is separate from, and in addition to, Medical Case Management, described in this Section ).

**8. Exceptional Needs Care Coordination (ENCC)**

**a.** Contractor shall provide Exceptional Needs Care Coordination to DMAP Members who are aged, blind or disabled consistent with OAR 410-141-0405, Exceptional Needs Care Coordination (ENCC).

**b.** Contractor must implement procedures to share the results of its identification and assessment of any DMAP Member with special health care needs with other PHPs serving the DMAP Member so that those activities need not be duplicated. Contractor shall create the procedures and share information under this Section 8 in compliance with the confidentiality requirements of this Contract.

**c.** Contractor shall have policies and procedures, including a standing referral process for direct access of specialists, in place for identifying, assessing and producing a treatment plan for each DMAP Member identified as having a special healthcare need. Each treatment plan will be:

**(1)** Developed by the DMAP Member's designated practitioner with the DMAP Member's participation;

**(2)** Include consultation with any specialist caring for the DMAP Member;

**(3)** Approved by the Contractor in a timely manner, if this approval is required; and

**(4)** In accordance with any applicable State quality assurance and utilization review standards.

**d.** For DMAP Members determined to need a course of treatment or regular care monitoring, Contractor shall have a written procedure in place to allow the DMAP Member to directly access a specialist as appropriate for the DMAP Member's condition and identified needs.

**9. Preventive Care**

**a.** Contractor shall provide Preventive Services, which are those services promoting health and/or reducing the risk of disease or illness included under OAR 410-120-1210, Medical Assistance Benefit Packages and Delivery System, OAR 410-141-0480, Oregon Health Plan Plus and Standard Benefit Package of Covered Services, and OAR 410-141-0520, Prioritized List of Health Services. Such services include, but are not limited to, periodic medical examinations based on age, sex and other risk factors; screening tests; immunizations; and counseling regarding behavioral risk factors.

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

**c.** For Preventive Care Services provided through any Subcontractors (including, but not limited to, Federally Qualified Health Centers, Rural Health Clinics and County Health Departments), Contractor shall require that all services provided to DMAP Members are reported to Contractor and are subject to Contractor's Medical Case Management and Record Keeping responsibilities.

**d.** Contractors shall comply with the mission, objectives, and guidelines of the Quality and Performance Improvement Workgroup, formerly Project: PREVENTION!, as identified in Schedule 2 of this Contract. This includes, but is not limited to, specific prevention projects, both at the Contractor and State levels, collection and measurement of data, and regular intervals of data submissions.

## 10. Family Planning Services

DMAP Members may receive Covered Services for Family Planning from any DMAP Provider. To the extent the DMAP Member chooses to receive such services without Contractor's authorization from a Provider other than Contractor or its Subcontractors, Contractor shall not be responsible for payment, Medical Case Management, or Record Keeping.

## 11. Sterilizations and Hysterectomies

**a.** Sterilizations are a Covered Service only when they meet the federally mandated criteria 42 CFR 441.250 to 441.259. Contractor shall obtain a signed informed consent only from the DMAP Member in accordance with OAR 410-130-0580 or have a Sterilization Order from the Circuit Court of the county in which the DMAP Member resides. Representatives are not allowed to give consent for sterilizations.

**b.** Hysterectomies are a Covered Service according to the criteria in 42 CFR 441.255 to 441.256 only when provided for medical reasons unrelated to sterilization. Contractor shall ensure all provisions regarding informed consent are met when performing a hysterectomy. Contractor shall obtain a signed informed consent form from the DMAP Member except:

**(1)** When the DMAP Member was already sterile prior to the procedure, in which case the performing or attending physician must certify in writing that the DMAP Member was already sterile and state the cause of the sterility; or

**(2)** The procedure was performed in a life-threatening emergency situation, in which case the performing or attending physician must certify in writing that prior consent by the DMAP Member was not possible and state the nature of the life-threatening emergency circumstances.

**c.** Contractor shall be subject to overpayment recovery as described in Exhibit C, Section 5, Subsection g., of this Contract for failure to comply with the requirements of this section.

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

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

## 13. Post Hospital Extended Care (PHEC) Coordination

**a.** Post Hospital Extended Care benefit is a 20-day benefit that is a Capitated Service, for non-Medicare DMAP Members enrolled with Contractor who meets Medicare criteria for a post-hospital skilled nursing facility placement.

**b.** Contractor shall notify the appropriate DHS office at the time DMAP Members are admitted to PHEC and begin appropriate discharge planning.

**c.** Contractors shall notify the DMAP Member and the facility of the proposed discharge date from PHEC no later than two full Business Days prior to discharge.

**d.** 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.

**e.** Contractor is not responsible for the PHEC benefit unless the DMAP Member was enrolled with Contractor at the time of the hospitalization preceding the nursing facility placement.

## 14. Chemical Dependency

Contractor shall provide Chemical Dependency Services to eligible DMAP Members, which include Outpatient Treatment Services, Opiate Substitution Services, and Intensive Outpatient Treatment Services. For purposes of this Contract, the DHS's Addiction and Mental Health Division (AMH) rules and criteria applicable to Outpatient treatment services are located in OAR 415-051-0000, and the AMH rules and criteria applicable to synthetic opiate treatment services located in OAR 415-020-0000. For purposes of this Contract, the AMH contact shall be the OHP Addiction Services.

**a.** 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 DMAP 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 ASAM 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.

**b.** Contractor shall consider each eligible DMAP 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 relevant, d) intravenous drug users, e) people involved with the criminal justice system and f) individuals with co-occurring disorders.

**c.** Consistent with Exhibit B, Part II, Section 1, Subsection d , Services Coordination for Non-Capitated Services, Contractor shall coordinate referral and follow-up of DMAP 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 DMAP 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; and legal services.]

**d.** Contractor shall authorize and pay for at least Outpatient Chemical Dependency Services to eligible DMAP Members who meet AMH criteria for residential treatment services, community detoxification, or opiate substitution maintenance, when services are not immediately available.

**e.** 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' most current publication "Client Process Monitoring System."

**f.** Contractor shall utilize AMH approved chemical dependency screening instruments to determine whether a diagnostic assessment for chemical dependency problems is indicated for a DMAP Member. Contractor may submit alternative screening instruments to AMH for review and possible approval.

**g.** Contractor shall make a good faith effort to screen all eligible DMAP Members who are in any of the following circumstances, for chemical dependency problems: a) at an initial contact or routine physical exam, b) at an initial prenatal exam, c) when the DMAP Member shows evidence of Trigger Conditions (as noted on the screening tool), or d) when the DMAP Member shows inappropriate over-utilization of Capitated Services.

**h.** Contractor shall ensure that only individuals or programs that have a Letter of Approval or license from AMH for the services provide Chemical Dependency Services they provide and meet all other applicable requirements of this contract.

**i.** Contractor shall refer at least 50% of eligible DMAP Members needing chemical dependency diagnostic and/or treatment to Essential Community Providers (ECP's), unless Contractor can document non-feasibility due to cost or quality of care. A list of ECP's is available from AMH upon request.

**j.** Contractor shall inform all eligible DMAP Members that chemical dependency Outpatient, intensive Outpatient, and opiate substitution treatment services are included in the Plus and Standard Benefit package, consistent with OAR 410-141-0300 Oregon Health Plan Prepaid Health Plan Member Education.

**k.** Contractor shall provide Covered Chemical Dependency treatment Services for any eligible DMAP Member who meets admission criteria for Outpatient, Intensive Outpatient and Opiate Substitution Treatment, regardless of prior alcohol/other drug treatment or education.

**l.** Contractor shall comply with the following access requirements: eligible DMAP Members shall be seen the same day for emergency Chemical Dependency Treatment care. Eligible DMAP Members, including pregnant women, shall be seen within 48 hours for urgent Chemical Dependency Treatment care. Eligible DMAP Members, including intravenous drug users, shall be seen within 10 days or the community standard for routine Chemical Dependency Treatment care.

**m.** 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 DMAP Members who receive Chemical Dependency Services.

**n.** Contractor shall identify specialized programs in each Service Area in the following categories that are to be used as exclusive Chemical Dependency Services Providers for: Drug Court referrals, Children, Adult and Families (CAF) referrals, Job Opportunities and Basic Skills (JOBS) referrals, and referrals for persons with co-occurring disorders.

**o.** Contractor shall provide DMAP Members with alcohol, tobacco, and other drug abuse prevention/education that reduces the risk for those DMAP Members who recently use those substances, and for those who do not. Contractor's prevention program shall meet or model national quality assurance standards. Contractor should have mechanisms to monitor the use of its preventive programs and assess their effectiveness on its DMAP Members.

## 15. Medication Management

**a.** 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. Prescription drugs and drug classes covered by Medicare Part D for fully dual eligible clients are not a Covered Service. DMAP will continue to cover selected drugs that are excluded from Medicare Part D coverage, pursuant to OAR 410-120-1210.

**b.** Contractor shall provide for a three day supply of any medication (other than those carved out of capitation such as Class 7 & 11 medications, Depakote, Lamictal and their generic equivalents) to be dispensed if that prescription requires a prior authorization that cannot be obtained by the date the prescription is to be filled.

**c.** Contractor may use a restrictive formulary as long as it allows access to other drug products not on the formulary through some process such as prior authorization. The formulary must include FDA approved drug products for each therapeutic class sufficient to ensure the availability of covered drugs with minimal prior approval intervention by the Provider of pharmaceutical services. The formulary must include at least one item in each therapeutic class of over-the-counter medications. The formulary must be revised periodically to assure compliance with this requirement. Contractor shall provide its Participating Providers and their pharmacy Subcontractor with its formulary and information about how to make non-formulary requests. If a drug cannot be approved within the 24 hour time requirement for preauthorization of medications and the medical need for the drug is immediate, Contractor must provide for the dispensing of at least a 72-hour supply of a drug that requires prior authorization. Contractor shall authorize the provision of a drug requested by the Primary Care Physician (PCP) or referral Provider, if the approved prescriber certifies medical necessity for the drug such as: the formulary's equivalent has been ineffective in the treatment or the formulary's drug causes or is reasonably expected to cause adverse or harmful reactions to the DMAP Member.

**d.** Contractor shall submit the information required in Schedule 3 and upon request, Contractor shall provide information to DMAP about utilization, quality, therapy, medical appropriateness and cost of prescribed medication.

**e.** Prescriptions for Physician Assisted Suicide under the Oregon Death with Dignity Act are excluded under this Contract; payment is governed solely by OAR 410-121-0150.

**f.** Contractor shall not authorize payment for any Drug Efficacy Study Implementation (DESI) Less-Than-Effective drugs that have reached the Federal Drug Administration Notice-of-Opportunity-for Hearing stage. The DESI Less-Than-Effective list is available at DMAP's website address: www.dhs.state.or.us/policy/healthplan/guides/pharmacy/misc_files/desi1.pdf

## EXHIBIT B –Statement of Work – Part II – Providers and Delivery System

### 1. Delivery System Configuration

#### a. Provider Capacity

Contractor shall maintain and monitor a panel of Participating Providers that is supported with written agreements (as specified in Exhibit D, Section 16) and has sufficient capacity to provide adequate, timely and Medically Appropriate Covered Services for Contractor's DMAP Members as required by this Contract and under OAR 410-141-0120, OHP Prepaid Health Plan Provision of Health Care services. In establishing and maintaining the network, Contractor shall:

**(1)** Offer an appropriate range of services and access to preventive and primary care services for the population enrolled or expected to be enrolled in the Service Area covered by this Contract;

**(2)** Utilize sufficient numbers and types (in terms of training, experience and specialization) of Providers of services consistent with the Plus and Standard Benefit Package of Covered Services;

**(3)** Consider the geographical location of Participating Providers and DMAP Members considering distance, travel time, the means of transportation ordinarily used by DMAP Members and whether the location provides physical access for DMAP Members with disabilities;

**(4)** Complete the Provider Capacity Report in Exhibit K as specified in Exhibit B, Part IV, Section 1, Subsection (4) and submit to the DHS 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;

**(5)** Utilize 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;

**(6)** Consider the expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented; and

**(7)** Consider the number of Participating Providers who are not accepting new DMAP Members.

**b. Accessibility**

**(1)** Contractor shall provide Medical Case Management Services for Covered Services and provide DMAP Members access to Covered Services. Contractor shall not discriminate between DMAP Members and non-DMAP Members, as provided in OAR 410-141-0220, OHP Prepaid Health Plan Accessibility.

**(2)** 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 DMAP 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 410-141-0220.

Contractor shall ensure that its employees, Subcontractors and facilities are prepared to meet the special needs of DMAP Members who require accommodations because of a disability or limited English proficiency. Contractor's Complaint and Appeal procedures, described in Exhibit B, Part III, Section 3 and in Exhibit N, shall include a process for Complaints and Appeals concerning communication or access to Covered Services or facilities.

**(3)** Contractor shall ensure that continuity of care is provided as required under OAR 410-141-0160, Oregon Health Plan Prepaid Health Plan Continuity of Care.

**(4)** Contractor is encouraged to establish agreements with hospitals in Contractor's Service Area for payment of emergency screening examinations consistent with ORS 441.094(5).

**(5)** Contractor shall ensure each DMAP Member has an ongoing source of primary care appropriate to the DMAP Member's needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished as described in OAR 410-141-0120 and required by 42 CFR 438.208 (b)(1).

**(6)** Contractor shall implement procedures to ensure that in the process of coordinating care, each DMAP Member's privacy is protected consistent with the confidentiality requirements in 42 CFR parts 160 and 164.

**(7)** Contractor shall provide female DMAP Members with direct access to women's health specialists within Contractor's Participating Provider panel for Covered Services necessary to provide women's routine and preventive health care services. This is in addition to the DMAP Member's designated PCP if the designated PCP is not a women's health specialist.

**(8)** Contractor shall provide for a second opinion from a qualified Participating Provider. If a qualified Participating Provider cannot be arranged then Contractor shall arrange for the DMAP Member to obtain the second opinion from a Non-Participating Provider, at no cost to the DMAP Member.

**c. Agreements with Public Health Organizations**

Consistent with ORS 414.153 and OAR 410-141-0120(2), Contractor shall execute Subcontracts with county health departments and other publicly supported programs and provide access to public health services. Contractor shall report to DMAP on the status in executing Subcontracts with publicly funded Providers and on the involvement of publicly supported health care and service programs on an annual basis with it's reporting under Exhibit K of this Contract.

**d. Services Coordination for Non-Capitated Services**

**(1)** Contractor shall coordinate services for each DMAP Member who requires medical assistance services not covered under the Capitation Payment. Contractor shall arrange, coordinate, and monitor Non-Capitated Services for medical, chemical dependency and mental health or dental health care for that DMAP Member on an ongoing basis, except as provided for in Paragraph (3) of this Subsection d.

**(2)** Contractor shall document its professional relationships with Local or Regional Allied Agencies, as defined in OAR 410-141-0000; community Emergency Service agencies; residential Chemical Dependency Services Providers; and local Non-Participating Providers which may offer services that are not Covered Services under the Capitation Payment.

**(3)** Contractor may not require DMAP 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. DMAP Members may refer themselves to MHO services.

**e. Cooperation with Mental Health Organizations (MHOs)**

**(1)** Contractors shall cooperate with MHOs as follows:

**(a)** Consult and communicate with the DMAP Member’s mental health Providers as Medically Appropriate and within the laws governing confidentiality as specified in OAR 410-141-0180, Prepaid Health Plan Record Keeping; and

**(b)** Develop and implement methods of coordinating with MHOs in order to assure appropriate coordination of services delivered to mutual DMAP Members, particularly DMAP Members with exceptional service needs. In additional to any other confidentiality requirements described in this Contract, such coordination shall be in accordance within laws governing confidentiality.

**f. Cooperation with Dental Care Organizations**

Contractor shall coordinate preauthorization and related services with Dental Contractor Organizations (DCOs) to ensure the provision of dental care that is required to be performed in an Outpatient hospital or ambulatory surgical setting due to the age, disability, or medical condition of the DMAP Member.

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

**(1)** Contractor shall coordinate the provision of Covered Services for DMAP Members, as appropriate, with residential, nursing facilities, foster care and group homes serving Contractor's DMAP Members.

**(2)** Contractor shall arrange to provide medication that is part of Capitated Services to nursing or residential facility and group or foster home residents in a format that is consistent with the individual facility's delivery, dosage and packaging requirements and Oregon law.

**h.** 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 under applicable State law, solely on the basis of such license or certification. This paragraph shall not be construed to prohibit Contractor from including Providers only to the extent necessary to meet the needs of DMAP Members or from establishing any measure designed to maintain quality and control costs consistent with Contractor's responsibilities under this Contract. This paragraph shall not be construed to preclude Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty.

**i. Medicare Payers and Providers**

**(1)** Contractor shall coordinate with Medicare payers and Providers as Medically Appropriate to coordinate the care and benefits of DMAP Members who are eligible for both Medicaid and Medicare.

**(2)** Contractor shall be responsible for Medicare deductibles, coinsurance and co-payments up to Medicare's or Contractor's allowable for Covered Services its Medicare eligible DMAP 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.

**j. Health Information Systems**

Contractor shall maintain a Health Information System that meets the requirements of this Contract and that will:

**(1)** Collect, analyze, integrate and report data that includes, but is not limited to:

**(a)** Appeals;

**(b)** Claims data;

**(c)** Complaints;

**(d)** Enrollment;

**(e)** Utilization of services; and

**(f)** Disenrollment for other than loss of Medicaid eligibility.

**(2)** Collect data at a minimum on:

**(a)** Provider characteristics as required in Exhibit K;

**(b)** DMAP Member characteristics;

**(c)** DMAP Member Enrollment; and

**(d)** Services provided to DMAP Members for Pharmacy, and Encounter Data reporting.

**(3)** Ensure Claims data received from Providers, either directly or through a third party submitter, is accurate, truthful and complete by:

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

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

**(c)** Submitting the certification contained in Exhibit H; and

**(d)** Collecting service information in standardized formats to the extent feasible and appropriate, if HIPAA standard Contractor must utilize the HIPAA standard including DHS Electronic Data Interchange (EDI) procedures.

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

**k. Evidenced-Based Clinical Practice Guidelines**

Contractor shall adopt evidenced-based clinical practice guidelines that are based on valid and reliable clinical evidence or a consensus of Health Care Professionals, in consultation with Contractor's Participating Providers, in the particular field. These evidenced-based clinical practice guidelines must consider the needs of Contractor's DMAP Members and be reviewed and updated periodically as appropriate. Contractor shall disseminate the evidenced-based clinical practice guidelines to all affected Participating Providers and, upon request, to DMAP, Contractor's DMAP Members, Potential DMAP Members or Representatives. Decisions for utilization management, coverage of services, or other areas, to which the guidelines apply, should be consistent

with the adopted evidenced-based clinical practice guidelines. Contractor shall describe in their annual written evaluation of the Quality Performance Improvement Program their process for adoption and dissemination of the evidenced-based clinical practice guidelines and identify those that have been adopted.

**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 DMAP Members to other Providers employed or subcontracted with Contractor, Contractor shall provide DMAP with a written plan for transferring the DMAP Members and an updated Provider Capacity Report, Exhibit K, at least ninety (90) days prior to the date of such action, notwithstanding the Contract renewal date. Contractor remains 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 DMAP Member care, less than the required notice to DMAP may be provided with the approval of DMAP.

**(2)** If a medical Provider or group terminates their subcontract or employment with Contractor or if Contractor is affected by circumstances beyond Contractor's control and the Contractor cannot reasonably provide the required ninety (90) days notice, less than the required notice to DMAP may be provided with the approval of DMAP.

**(3)** If Contractor cannot demonstrate sufficient Provider capacity, DMAP reserves the right to seek other avenues to provide services to DMAP Members. If DMAP determines that some or all of the affected DMAP 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 Contractor's Service Area and/or Disenrolling a substantial number of DMAP Members from Contractor, Contractor shall provide DMAP with a written notice and a plan for implementation (which may include an intent to transfer its DMAP Members in the Service Area to a designated Contractor) at least 90 days prior to the date of such action, notwithstanding the Contract renewal date. Contractor remains responsible for providing all Capitated Services through the end of the 90-day period, without limitation, for all DMAP Members for which the Contractor received a Capitation Payment.

**(1)** If Contractor must terminate a medical Provider or group due to circumstances that could compromise DMAP Member care, less than the required notice to DMAP may be provided with the approval of DMAP.

**(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 DMAP may be provided with the approval of DMAP.

**(3)** If Contractor provides DMAP with the required 90-day notice but provides no Letter of Intent to transfer its DMAP Members to a designated Contractor within 30 days of the 90-day notice, DMAP Members enrolled with Contractor 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 DMAP with the required 90-day notice and also provides a Letter of Intent to transfer its DMAP Members to a designated Contractor, and DMAP determines that the designated Contractor(s) will have sufficient Provider capacity as of the date of the proposed transfer, DMAP may approve the Disenrollment and transfer of DMAP Members and develop such Contract amendment(s) as may be necessary to effect the transfer.

**(5)** DMAP reserves the right to seek other avenues to provide services to the DMAP Members in the affected area(s).

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

**d.** Contractor is responsible for completing submission and corrections to Encounter Data for services received by DMAP Members; and for assuring payment of Valid Claims by employees and Subcontractors, and for Non-Participating Providers providing Covered Services to DMAP Members; and for compliance with such other terms of this Contract applicable to the dates of service before Disenrollment of DMAP Members pursuant to this section. DMAP may, in its discretion, withhold 20% of Contractor's Capitation Payment until all contractual obligations have been met to DMAP's satisfaction. Failure to complete or ensure completion of said contractual obligations within a reasonable period of time shall 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 shall accept all assigned or transferred OHP Clients without regard to the Enrollment exemptions in OAR 410-141-0060. This provision does not apply to a Medicare Advantage plan's fully dual eligible members.

**f.** If this Contract is amended to reduce the Service Area and/or to reduce the Enrollment limit, the Capitation 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 Capitation 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 Capitation 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 Capitation 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. Quality and Performance Improvement Requirements

Contractor shall maintain an internal Quality and Performance Improvement Program based on written policies, standards and procedures that are designed to achieve through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas and that are expected to have a favorable effect on health outcomes and DMAP Member satisfaction. (See Subsection e.(1) of this section, for examples of non-clinical areas). The Quality and Performance Improvement Program shall be in accordance with accepted professional standards consistent with OAR 410-141-0200, OHP Managed Care Organization Quality Improvement System, and consistent with 42 CFR 438.200 Subpart D, Quality Assessment and Performance Improvement.

**a.** Contractor shall submit performance measures to DMAP, in conformance with 42 CFR 438.240(c), Performance Improvement measurements, which include:

**(1)** Asthma Care. Contractor shall report Oregon Asthma Program/Asthma Data Workgroup Pharmacotheraphy, Emergency Department Visits and Follow-up Care components of the Asthma Care indicators, on an electronic data submission form supplied by the Oregon Asthma Data Workgroup (see Schedule 1 for a model). This measure shall be reported for the DMAP Member population. Contractors shall follow the data collection and reporting methodologies according to standards set in the Oregon Asthma Data Workgroup Technical Specifications developed for the OHP Quality and Performance Improvement Workgroup (QPIWG) that are in effect for the reporting year. Contractor shall submit the Asthma Care measure to the designated DMAP Performance Measure Coordinator by August 1 of the Contract Year;

**(2)** Childhood Immunization Status for children age birth to 36 months. DMAP will collect immunization rates based on the Advisory Committee on Immunization Practices (ACIP) standards for Contractor from Immunization ALERT. DMAP and Immunization ALERT will follow the standard data collection and reporting methodologies developed by ACIP, QPIWG and DMAP that are in effect for the reporting period. Immunization measures shall be submitted by ALERT to the designated DMAP Performance Measure Coordinator and Contractor by September 30th of the Contract Year;

**(3)** DMAP will collect and report response rates for Consumer Assessment of Health Plan Survey (CAHPS®) Advising Smokers to Quit questions;

**(4)** DMAP may modify, replace or eliminate reporting requirements or time frames of the performance measures specified in Subsection a.(1) through (3) of this Section, based on consultation with the Quality and Performance Improvement Workgroup or an assessment by DMAP in consultation with Contractor of the Contractor's capabilities for reporting;

**(5)** DMAP reserves the right to publish the reported performance measures with notations on methodology and statistical significance;

**(6)** The performance measures reporting requirements measure the quality of health care and services during a time period in which Contractor was providing OHP Capitated Services. The performance measures reporting requirements expressly survive the expiration, termination or amendment of this Contract, even if contract expiration, termination or amendment results in a termination, modification or reduction of the Contractor's services area, since performance measures services are rendered when the Contractor is providing Capitated Services under this Contract; and

**(7)** Organizations which are governed by ORS 743.814 (3) shall report 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 shall be provided to the DMAP Quality Improvement Coordinator concurrent with submission to DCBS.

**b. External Quality Review and Improvement**

**(1)** 42 CFR 438.204 (d) and 42 CFR 438.310-438.370 require DMAP to arrange for an External Quality Review (EQR) of the services provided by Contractor. The EQR is an analysis and evaluation of performance improvement projects and measures, and structure and operations of the Contractor or its Subcontractors. The External Quality Review Organization (EQRO) is an organization that meets the independence and competency requirement in 42 CFR 438.354 and performs EQR activities outlined in 42 CFR 438.358 or both. DMAP implements this external review requirement by contracting with an EQRO and authorizing the EQRO to contact Contractor to obtain information for the purpose of the EQR. The Centers for Medicare and Medicaid Services may also

contract with an EQRO or Quality Improvement Organization to conduct EQR of the services provided under this Contract. Contractor shall cooperate with CMS' external review process.

**(2)** Contractor shall cooperate with the EQRO and shall provide whatever records and information is requested by the EQRO for purposes of the EQR. Contractor may direct EQRO to obtain the requested information from DMAP if Contractor already has submitted the requested information to DMAP. Contractor shall require, through written agreements with Contractor's Subcontractors, a requirement that the Subcontractors shall cooperate with and provide all the records and information the EQRO may request.

**(3)** If the EQRO identifies an adverse health situation, the EQRO shall immediately report the findings to DMAP and Contractor. Upon receipt of such report Contractor shall assign a staff person(s) to follow-up with Participating Providers, assure that necessary care is provided, and report on the results to DMAP and the EQRO. If determined by DMAP, at the recommendation of the EQRO, Contractor shall develop and comply with a Corrective Action Plan as specified by DMAP.

**(4)** EQRO will provide the results of the EQR to the Contractor, to DMAP and upon request to CMS, Office of Inspector General, and the United States Comptroller General.

**c. DMAP Quality Improvement Evaluation (QIE)**

42 CFR 438.202 requires DMAP to have a strategy for assessing and improving the quality of Capitated Services offered, ensuring compliance with standards established by DMAP, and to conduct periodic reviews to evaluate the effectiveness of the strategies. The QIE is one form of periodic review of Contractor's Quality and Performance Improvement Program (QPI) and the State quality improvement strategy.

Contractor shall cooperate with DMAP and supply those records and information required by Contract and described in OAR 410-141-0200, OHP Prepaid Health Plan Quality Improvement System, that are requested by the QI Team for the purposes of the QIE review. The QI Team will review all requested and reported materials to determine Contractor's compliance with rules and Contract; to assess Contractor's quality improvement program, and to establish standards in determining the need for additional review of appropriate medical/dental management practices and utilization levels.

**d.** Contractor's Quality and Performance Improvement Program must have ongoing performance improvement projects for the Covered Services it provides to Contractor's DMAP Members. Contractor's performance improvement projects must be designed to achieve through ongoing measurements and intervention, significant improvement sustained over time that are expected to have a favorable effect on DMAP Member health outcomes and satisfaction. The provision to submit the status and results of performance improvement projects shall survive for one year following the date of Contract expiration or termination.

**(1)** Contractor must measure and report to DMAP the results of performance improvement projects for the previous calendar year. Contractor must use either the performance improvement projects identified in Paragraph (2) of this subsection below and as specified in Schedule 2, or no less than two performance improvement projects Contractor has initiated.

If Contractor chooses not to use the performance improvement projects described in Schedule 2, Contractor-initiated performance improvement projects must be reviewed by and have prior approval of DMAP and must focus on clinical and non-clinical areas and involve the following:

**(a)** Measurement of performance using objective quality indicators;

**(b)** Implementation of system interventions to achieve improvement in quality;

**(c)** Evaluation of the effectiveness of the interventions;

**(d)** Planning and initiation of activities for increasing or sustaining improvements; and

**(e)** Contractor must report the status and results of each Contractor-initiated performance improvement project to DMAP annually in the Quality and Performance Improvement (QPI) annual report described in this Exhibit B, Part II, Section 3, Subsection e, by March 15, for the previous calendar year, or on a mutually agreed upon date specified by DMAP and Contractor. This Paragraph (1) of this subsection shall survive Contract termination or expiration.

**(2)** If Contractor does not initiate performance improvement projects meeting the standards identified above, Contractor must use performance improvement projects as outlined in Performance Improvement Projects (PIP) Schedule 2. The current performance improvement projects include asthma and the mental health/ physical health Collaborative PIP.

Written reports and re-measurement, as specified in Schedule 2, for asthma shall be submitted by Contractor annually no later than August 1, 2008 (or on a date mutually agreed to by DMAP and Contractor) for the previous calendar year. Additionally, Contractor shall submit the asthma baseline by March 15, 2008. The State will complete Activity 1 for the asthma project.

Written reports and re-measurement, as specified in Schedule 2 for the Collaborative PIP shall be submitted by Contractor annually no later than August 1, 2009 (or on a date mutually agreed to by DMAP and Contractor) for the previous calendar year. Additionally, Contractor shall submit the Collaborative PIP baseline by March 15, 2008. The Collaborative baseline minimum requirement is Activity 1, 2 and 3. The State will complete Activity 1 for the mental health/ physical health Collaborative.

The results of reports and re-measurement shall be made available by DMAP annually for Contractor.

**(3)** A Quality and Performance Improvement Workgroup will meet regularly throughout each Contract Year. Contractor will designate a liaison to participate in the Quality and Performance Improvement Workgroup with DMAP oversight to provide a review and approval of revised or newly developed performance improvement projects to be specified in Schedule 2.

**(4)** The performance improvement project revisions to Schedule 2 shall be mutually agreed to by DMAP and Contractor and incorporated either by amendment, as designated in Exhibit D, Section 18 of this Contract, if additional or revised performance projects are developed, or at Contract renewal. Requested changes must meet the time lines for amendments or Contract renewal as stipulated by DMAP. Revisions to performance projects and Schedule 2 that do not meet DMAP's time lines for revision will be incorporated at DMAP's discretion.

**(5)** Contractor shall demonstrate sustained improvement of previous PIP topics by continuing to document, in each subsequent reporting period, the ongoing focused PIP measurement and associated interventions which results in the associated health outcomes and enrollee satisfaction improvements. Documentation of sustainability must also be submitted on March 15, for the previous calendar year, as an inclusion of the QI Annual Report.

**(6)** Notwithstanding the requirements in this section, in conformance with 42 CFR 438.240(a)(2), Contractor will comply with performance improvement projects required by CMS, which will be coordinated by DMAP.

**e.** In conformance with 42 CFR 438.240 Contractor shall submit to DMAP an annual written evaluation of Contractor's Quality and Performance Improvement (QPI) Program. The evaluation of the QPI program and DMAP Member care shall include a description of completed and ongoing QI activities in clinical and non-clinical areas, and an evaluation of the QPI program's overall effectiveness. Contractor may submit reports, materials or information that are relevant to this Subsection e, paragraphs (1), (2), (3), or (4) that Contractor had already submitted to DMAP for QIE or to the EQRO. This evaluation shall include, 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 of care. Such projects may include review of: clinical records, utilization reviews, referrals, co-morbitities, prior authorizations, emergency services, out of Contractor's 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 DMAP Members who are aged, blind, disabled or children receiving Child Welfare or Oregon Youth Authority services (or DMAP Members with special health care needs), including Contractor review of the Exceptional Needs Care Coordination program, and any adverse events for the DMAP Members;

**(3)** Results of review of Contractor's utilization review mechanisms to detect both under-utilization and over-utilization of services;

**(4)** A report on the process for adoption and dissemination of Contractor's evidenced-based clinical practice guidelines; and the identification of specific adopted guidelines; and

**(5)** The annual QPI report, for the previous calendar year shall be submitted to DMAP by March 15 of the Contract Year, or on a mutually agreed upon date specified by DMAP and Contractor.

## 4. Credentialing

**a.** Contractor shall have written policies and procedures for collecting evidence of credentials, screening the credentials, reporting credential information, as specified in Exhibit K, and requiring recredentialing of Participating Providers, programs and facilities used to deliver Covered Services, consistent with OAR 410-141-0120, Oregon Health Plan Prepaid Health Plan Provision of Health Care Services, 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 K 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.

## EXHIBIT B –Statement of Work – Part III – Members

### 1. Informational Materials and Education of DMAP Members and Potential DMAP Members

**a.** Contractor shall provide all of Contractor's enrollment notices, informational materials and instructional materials relating to DMAP Members and Potential DMAP Members in a manner and format that may be easily understood.

**b.** Contractor shall have in place a mechanism to help DMAP Members and Potential DMAP Members understand the requirements and benefits of Contractor's plan, consistent with the requirements of OAR 410-141-0300, Oregon Health Plan Prepaid Health Plan Member Education, and OAR 410-141-0280, Oregon Health Plan Prepaid Health Plan Informational Requirements.

**c.** Contractor shall make written information available in the prevalent non-English languages in its particular Service Area(s), using the criteria in OAR 410-141-0280(2).

**d.** Contractor shall make oral interpretation services available free of charge to each Potential DMAP Member and DMAP Member. This applies to all non-English languages, not just those that the DHS has identified as a prevalent language.

**e.** Contractor shall make its written material available in alternative formats and in an appropriate manner that takes into account the special needs of those who, for example, are visually limited or have limited reading proficiency. All DMAP Members and Potential DMAP Members must be informed that Contractor's written information is available in alternative formats and how to access those formats.

**f.** Contractor shall develop informational materials for Potential DMAP Members. Contractor shall also provide that information to DMAP as required by OAR 410-141-0280.

**(1)** Contractor shall provide DMAP with informational materials sufficient for the Potential DMAP Member to make an informed decision about Contractor selection and Enrollment. A summary of the following information is sufficient, but Contractor must provide more detailed information to the DMAP Member upon request:

**(a)** Names, locations, telephone numbers of, and non-English language spoken by current Participating Providers, and including identification of Participating Providers that are not accepting new patients. This information must include, at a minimum, information on primary care physicians, specialists and hospitals; and

**(b)** Identify any counseling or referral service that the Contractor does not cover because of moral or religious objection.

**(2)** Contractor shall ensure that all Contractor's staff who have contact with Potential DMAP Members are fully informed of Contractor policies, including Enrollment, Disenrollment, Complaint and Appeal policies and the provision of interpreter services including the Participating Providers' offices that have bilingual capacity.

**g.** Contractor must furnish to each of its DMAP Members the information specified in 42 CFR 438.10(f)(6) and 42 CFR 438.10(g), if applicable, within a reasonable time after the Contractor receives notice of the recipient's enrollment from the State. Contractor shall notify all DMAP Members of their right to request and obtain the information described in this paragraph at least once a year.

**h.** Contractor shall provide written notice to affected DMAP Members of any Material Change in the information described in Subsection g, of this section, that is reasonably likely to impact the affected DMAP Members' ability to access care or services from Contractor's Participating Providers. Such notice shall be provided at least 30 days prior to the effective date of those changes, or as soon as possible if the Participating Providers(s) has not given the Contractor sufficient notification to meet the 30 days notice requirement. DMAP will review and approve such materials within two (2) Business Days.

## 2. DMAP Member Rights

**a.** Contractor shall require, and cause its Participating Providers to require, that DMAP Members are treated with respect, due consideration for his or her dignity and privacy, and the same as non-DMAP Members or other patients who receive services equivalent to Covered Services consistent with the requirements of this Contract and OAR 410-141-0320, OHP Member Rights and Responsibilities.

**b.** Contractor shall comply with, and require its staff, Subcontractors and Participating Providers to comply with, any applicable federal and State laws that pertain to DMAP Member rights, and shall take those rights into account when furnishing services to DMAP Members.

**c.** Contractor shall provide equal access for both males and females under 18 years of age to appropriate facilities, services and treatment under this Contract, consistent with DMAP's obligations under ORS 417.270.

**d.** Contractor shall allow each DMAP Member to choose his or her health professional from available Participating Providers and facilities to the extent possible and appropriate. For a DMAP Member in a Service Area serviced by only one PHP, any limitation the Contractor imposes on his or her freedom to change between primary care Providers may be no more restrictive than the limitation on Disenrollment under Exhibit B, Part III, Section 4, Subsection b, of this Contract.

**e.** Contractor shall require, and cause its Participating Providers to require, that DMAP Members receive information on available treatment options and alternatives, presented in a manner appropriate to the DMAP Member's condition and ability to understand.

**f.** Contractor shall require, and cause its Participating Providers to require, that DMAP Members be allowed to participate in decisions regarding their health care, including the right to refuse treatment and to express preferences about future treatment decisions.

**g.** Contractor shall ensure DMAP 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.** Contractor shall make oral interpretation services available free of charge to each Potential DMAP Member and DMAP Member. This applies to all non-English languages not just those that DHS identifies as prevalent.

**i.** Contractor shall notify its DMAP Members and Potential DMAP Members that oral interpretation is available for any language and that written information is available in prevalent non-English languages in Contractor's particular Service Area(s).

**j.** Contractor shall notify its DMAP Members how to access oral and written interpretation services.

**k.** Contractor shall make a good faith effort to provide its DMAP Members written notice of termination of a Participating Provider. Notice must be issued within 15 days after receipt or issuance of the termination notice, to each enrolled DMAP Member who received his or her primary care from, or was seen on a regular basis by, the terminated Participating Provider.

**l.** Contractor shall ensure, and cause its Participating Providers to ensure, that DMAP Members may request and receive a copy of his or her medical records and request that they be amended or corrected as specified in 45 CFR Part 164.

**m.** Contractor shall ensure, and shall cause its Participating Providers to ensure, that each DMAP 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 or Participating Providers, treat the DMAP Member. Contractor shall not discriminate in any way against Contractor's DMAP Members when those DMAP Members exercise their rights under the OHP.

**n.** At a DMAP Member's request, Contractor shall provide information on the structure and operation of the Contractor's organization and any physician incentive plan. Contractor shall provide information on advance directives as required in Exhibit E, Section 15, of this Contract.

**o.** Any cost sharing authorized under this Contract for DMAP Members must be in accordance with 42 CFR 447.50 through 42 CFR 447.60 and with the General Rules.

## 3. Grievance System

**a.** Each time a Covered Service or benefit will be denied, terminated, suspended or reduced, or when Contractor authorizes a course of treatment or Covered Service but subsequently acts to terminate, discontinue or reduce the course of treatment or a Covered Service, Contractor shall issue a Notice of Intended Action (NOA) to the affected DMAP Member at least 10 Business Days before the date of the Action unless there is documentation that the DMAP Member had previously agreed to the change as a part of the course of treatment. Contractor shall comply with Exhibit N and the notice requirements in OAR 410-141-0263, Notice of Action by a PHP, including information about continuation of benefits.

**b.** Contractor shall have written procedures approved in writing by DHS for accepting, processing and responding to all Complaints and Appeals from DMAP Members, consistent with the requirements of Exhibit N and OAR 410-141-0260 through 410-141-0266, including Complaints and Appeals related to requests for accommodation in communication or provision of services for DMAP Members with a disability or limited English proficiency.

DHS reviews the Contractor's procedures for compliance with the requirements of Exhibit N and OAR 410-141-0260 through OAR 410-141-0266, as well as any applicable federal requirements, including 42 CFR 438.

**c.** In the event a DMAP Member or their Representative requests an administrative hearing from DMAP, Contractor shall comply with the requirements of Exhibit N and OAR 410-141-0264, Administrative Hearings.

**d.** Contractor shall maintain a log of all DMAP Member Complaints and Appeals. The log shall identify the DMAP Member, the date of the Complaint, the resolution and the date of resolution. Contractor shall retain Complaint and Appeal logs for 7 years. This provision shall survive expiration or termination of this Contract.

**e.** Contractor shall provide to DMAP a quarterly report summarizing DMAP Member Complaints, using the report format in Exhibit L.

**f.** Contractor and its Subcontractors shall cooperate with the DHS's ombudsman and the DHS's hearing representatives in all of the DHS's activities related to DMAP Member Complaints, Appeals, and administrative hearings.

**g.** Contractor shall inform DMAP Members about the Contractor's Complaint and Appeal procedures and timeframes, the availability of assistance in the filing process, the toll-free numbers that a DMAP Member can use to file a Complaint or Appeal by phone, how to request continuation of benefits (and DMAP Member responsibility to pay for the cost of services furnished while an Appeal or administrative hearing is pending if the final decision is adverse to the DMAP Member), and how to access a DMAP administrative hearing at the time of the DMAP Member's Enrollment.

## 4. Enrollment and Disenrollment

### a. Enrollment

**(1)** "Enrollment" is the process by which DHS signs on with a particular Contractor those OHP Clients who have been determined to be eligible for services under the OHP Medicaid Demonstration Project and/or the Children's' Health Insurance Program. Enrollment is voluntary on the part of the DMAP Member, except in the case of mandatory enrollment, pursuant to OAR 410-141-0060. DHS will sign on such OHP Clients with the contractor selected by the OHP Client unless, pursuant to OAR 410-141-0060, DHS assigns the OHP Client to a contractor because the OHP Client failed to select a contractor. "Automatic reenrollment" of a DMAP Member with the same contractor occurs if the DMAP Member is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.

Except as otherwise provided in this Section 9, 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 by DHS, unless DMAP and/or Contractor have closed Enrollment with Contractor as described in Paragraph (3) Item (a) of this subsection. Contractor shall not

discriminate against individuals eligible to enroll on the basis of 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.

**(2)** 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 DHS.

**(a)** A period of open Enrollment shall commence on the first day of the month after the month in which DMAP determines that the Contractor's Enrollment is 20% or more below their Enrollment limit, established in Part V, Section 2 of this Contract.

**(b)** Enrollment shall remain continuously open until the first day of the month after the month in which DMAP determines that the Contractor's Enrollment is 20% or less above their Enrollment limit established in Part V, Section 2 of this Contract.

**(c)** Contractor shall have not less than 30 continuous days of open Enrollment every Contract Year. The open Enrollment periods for consecutive Contract Years may not be more than 14 months apart. If these requirements could cause Contractor to exceed the ceiling established in Paragraph (2), Item (b) of this subsection, Contractor shall consult with DMAP about whether an amendment of this Contract should be authorized.

**(3)** Enrollment may be closed by DMAP, or by Contractor notifying the designated DMAP PHP Coordinator, because Contractor's maximum Enrollment has been reached or for any other reason mutually agreed to by DMAP and Contractor, or as otherwise authorized under this Contract.

**(a)** Notification by Contractor to the DMAP PHP Coordinator shall be no less than 15 days prior to the anticipated closure date or a specified time period mutually agreed to by DMAP and Contractor. The date DMAP receives notification does not qualify as one of the 15 notification days.

**(b)** Notification by DMAP to Contractor shall be no less than 15 days prior to the anticipated closure date or a specified time period mutually agreed to by Contractor and DMAP. The date Contractor receives notification does not qualify as one of the 15 notification days.

**(4)** If Contractor is assigned or transferred OHP Clients pursuant to Exhibit B, Part II, Section 2 of this Contract, Contractor shall accept all assigned or transferred OHP Clients without regard to the Enrollment exemptions in OAR 410-141-0060. This provision does not apply to a Medicare Advantage plan's fully dual eligible members. Contractor will not, on the basis of health status or need for health services, discriminate against Potential DMAP Members.

**(5)** Enrollment of OHP Clients with Contractor shall occur on a weekly and monthly basis. For weekly Enrollment, a week shall begin on Monday and end the following Sunday. If Enrollment is initiated by a DHS employee on or before Wednesday, the

date of Enrollment shall be the following Monday. If Enrollment is initiated by a DHS employee after Wednesday, the date of Enrollment shall be one week from the following Monday. For monthly Enrollment, the date of Enrollment with Contractor shall be the first of the month following the month-end cutoff (four (4) Business Days before the end of the month). These dates of Enrollment shall apply in all cases except:

**(a)** For newborns, whose mother was enrolled with Contractor at the time of birth, the date of Enrollment with Contractor shall be the newborn's date of birth;

**(b)** For persons who are enrolled with Contractor on the same day as they are admitted to the hospital, Contractor shall be responsible for said hospitalization. If the person is enrolled after the first day of the Inpatient stay, the person shall be Disenrolled, and the date of Enrollment shall be the next available Enrollment date following discharge from Inpatient hospital services;

**(c)** For persons who are reenrolled within 30 days of Disenrollment, the date of Enrollment shall be the date specified by DMAP, which may be retroactive to the date of Disenrollment;

**(d)** For persons who are automatically reenrolled with Contractor, the date of Enrollment shall be the date specified by DMAP; and

**(e)** For adopted children or children placed in an adoptive placement, the date of Enrollment shall be the date specified by DMAP.

**(6)** If DMAP enrolls an OHP Client with Contractor in error, and the erroneously enrolled OHP Client has not received services from Contractor, DMAP may retroactively Disenroll the DMAP Member from Contractor and enroll the OHP Client with the originally intended contractor up to sixty (60) days from the date of the erroneous Enrollment, and the Capitation Payment to Contractor shall be adjusted accordingly.

**b. Disenrollment**

The requirements and limitations governing Disenrollments contained in 42 CFR 438.56, Disenrollment Requirements, apply to all managed care arrangements whether Enrollment is mandatory or voluntary, except to the extent that 42 CFR 438.56(c)(2)(i) is expressly waived by CMS. If Contractor receives a request for Disenrollment from a DMAP Member or their Representative, Contractor shall submit the request to DMAP within 10 business days.

**(1)** An individual is no longer a DMAP Member for purposes of this Contract as of the effective date of the individual's Disenrollment from Contractor, and as of that date, Contractor is no longer required to provide services to such individual by the terms of this Contract, unless the DMAP Member is hospitalized at the time of Disenrollment. In such an event, Contractor is responsible for Inpatient hospital services until discharge or until the DMAP Member's primary care Provider determines that care in the hospital is no longer Medically Appropriate. DMAP will assume responsibility for other services not included in the Diagnostic Related Group (DRG).

**(2)** A DMAP Member may be Disenrolled from Contractor as follows:

**(a)** If requested orally or in writing by the DMAP Member or the Representative, DHS may Disenroll the DMAP Member in accordance with OAR 410-141-000 and 410-141-0080(1)(b), OHP Disenrollment from PHPs, for the following reasons:

**(i)** Without cause:

**(A)** After six months of DMAP Member's Enrollment;

**(B)** Upon automatic reenrollment (e.g., a recipient who is automatically reenrolled after being disenrolled, solely because he or she loses Medicaid eligibility for a period of 2 months or less), if the temporary loss of Medicaid eligibility has caused the DMAP Member to miss the annual disenrollment opportunity; or

**(C)** Whenever the DMAP Member's eligibility is re-determined by DHS.

**(ii)** With cause:

**(A)** At any time;

**(B)** The DMAP Members has Disenrolled from a Medicare Advantage plan;

**(C)** A DMAP Member receiving Medicare requests Disenrollment from Contractor who is the corresponding Medicare Advantage plan;

**(D)** The Contractor does not, because of moral or religious objections, cover the service the DMAP Member seeks;

**(E)** The DMAP Member needs related services (for example a cesarean section and a tubal ligation) to be performed at the same time, not all related services are available within the network, and the DMAP Member's Primary Care Provider or another Provider determines that receiving the services separately would subject the DMAP Member to unnecessary risk; or

**(F)** Other reasons, including but not limited to, poor quality of care, lack of access to services covered under this Contract, or lack of access to Participating Providers experienced in dealing with the DMAP Member's health care needs. Examples of sufficient cause include but are not limited to:

**(I)** The DMAP Member moves out of the Contractor's Service Area;

**(II)** It would be detrimental to the DMAP Member's health to continue enrollment;

**(III)** The DMAP Member is a Native American or Alaskan Native; or

**(IV)** For continuity of care.

The effective date of Disenrollment when requested by a DMAP Member shall be the first of the month following DHS' approval of Disenrollment. The effective date of Disenrollment for DMAP Members who Disenroll from Contractor's Medicare Advantage plan shall be the first of the month that their MedicareAdvantage Disenrollment is effective. If the DHS fails to make a Disenrollment determination by the first day of the second month following the month in which the DMAP Member files a request for Disenrollment, the Disenrollment is considered approved.

**(b)** DHS may Disenroll a DMAP Member upon request by Contractor because the DMAP Member:

**(i)** Is unruly or abusive to others (except as excluded in Paragraph (2), Item (d), (iv) or (v) of this subsection;

**(ii)** Threatens or commits an act of physical violence pursuant to OAR 410-141-0080;

**(iii)** Committed fraudulent or illegal acts such as permitting the use of his or her DMAP Medical Care Identification by another person pursuant to OAR 410-141-0080;

**(iv)** Is suspected of altering a prescription;

**(v)** Is suspected of theft or other criminal acts committed in any Provider's or Contractor's premises;

**(vi)** Otherwise misused the Medical Assistance Program; or

**(vii)** Satisfies any of the other reasons specified in OAR 410-141-0080(2), except non-payment of co-payments under OAR 410-141-0080 (2)(A)(vi).

Contractor must submit requests for Disenrollment in writing, detailing the specific reason as required in OAR 410-141-0080(2)(a)(C) and this Contract, to their PHP Coordinator for prior approval except where otherwise specified in OAR 410-141-0080.

**(c)** DHS may Disenroll the DMAP Member and other individuals in the DMAP Member's Benefit Group in accordance with OAR 410-141-0080, OHP Disenrollment from PHPs. The effective date of Disenrollment when requested by Contractor shall be the date of Contractor's request for Disenrollment, subject to any administrative hearing by the DMAP Member.

**(d)** Contractor shall not request Disenrollment of a DMAP Member for reasons related to:

**(i)** An adverse change in the DMAP Member's health status;

**(ii)** A need for health services;

**(iii)** Diminished mental capacity;

**(iv)** Uncooperative or disruptive behavior resulting from the DMAP Member's special needs (except when the continued Enrollment seriously impairs Contractor's ability to furnish services to either this DMAP Member or other DMAP Members);

**(v)** A disability or any condition that is a direct result of their disability, unless otherwise specified in OHP Administrative Rule; or

**(vi)** Other reasons specified in OAR 410-141-0080(2)(B).

**(e)** If DMAP determines that the DMAP Member has sufficient Third Party Resources such that health care and services should be provided on a fee-for-service basis instead of on a prepaid capitated basis, DHS may Disenroll the DMAP Member. The effective date of Disenrollment shall be specified by DMAP. If the DMAP Member Appeals the Disenrollment, all DMAP Members of the enrolled Benefit Group will remain enrolled with Contractor until the administrative hearing has been adjudicated.

**(f)** If DMAP determines that Contractor's DMAP Member has enrolled with their Employer Sponsored Insurance (ESI) through FHIAP, the effective date of the Disenrollment shall be the DMAP Member's effective date of coverage with FHIAP.

**(3)** Contractor shall inform DMAP immediately upon receiving notice that a DMAP Member has requested Disenrollment from or has been Disenrolled from Contractor's Medicare Advantage plan.

**(4)** If Contractor has knowledge of a DMAP Member's change of address, or death, Contractor shall notify DHS by using the toll-free number (800) 699-9075.

**(a)** If the DMAP Member moves out of Contractor's Service Area(s), the effective date of Disenrollment shall be the date specified by DMAP, which may be retroactive.

**(b)** If the DMAP Member dies, the effective date of Disenrollment shall be the end of the month during which the death occurred. DMAP will recoup from Contractor any Capitation Payments made after the date of Disenrollment.

**(5)** If the DMAP Member is no longer eligible under the Medical Assistance Program, the effective date of Disenrollment shall be the date specified by DMAP.

**(6)** If DHS Disenrolls a DMAP Member retroactively, any Capitation Payments received by Contractor after the effective date of Disenrollment shall be recouped by DMAP. If the Disenrolled DMAP Member was otherwise eligible for the OHP, services they received during the period of the retroactive Disenrollment may be eligible for fee-for-service payment under DMAP rules.

**(7)** If DHS Disenrolls a DMAP Member due to a DHS administrative error, and the DMAP Member has not received services from another contractor, the DMAP Member may be retroactively re-enrolled with Contractor up to sixty (60) days from the date of Disenrollment.

**(8)** Disenrollment required by adjustments in Service Area or Enrollment shall be governed by Exhibit B, Part II, Section 2 of this Contract.

**c. Benefit Package Changes**

The Weekly and Monthly Enrollment file (as described in Exhibit C, Section 4 of this Contract) will identify Contractor's DMAP Member eligibility status for either the Plus or the Standard Benefit Package. The file does not include any historical data on DMAP Member's eligibility status. A benefit package change due to a DMAP Member's eligibility status may constitute Disenrollment.

## 5. Identification Cards

Contractor shall issue identification cards to DMAP Members, unless waived by DMAP. Such identification cards shall be for DMAP Members' and Providers' convenience only and shall confer no rights to services or other benefits under this Contract. To be entitled to such services or benefits, the holder of the identification card must, in fact, be a current DMAP Member with Contractor.

## 6. Marketing

**a.** Contractor shall not and cause its agents, Subcontractors, and Subcontractor's agents to not initiate contact nor market (as defined in OAR 410-141-0000) 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 DMAP. Contractor may not conduct, directly or indirectly, door-to-door, telephonic, mail, electronic, or other Cold Call Marketing practices (as defined in OAR 410-141-0000) to entice DMAP OHP Client to enroll with Contractor, or to not enroll with another Contractor. Contractor or Subcontractors or their agents shall not seek to influence an OHP Client's Enrollment with the Contractor in conjunction with the sale of any other insurance.

**b.** Subject to Subsection d, of this section, Contractor may engage in activities under Exhibit B, Parts I through VI, or activities intended to provide outreach to Contractor's existing DMAP Members for the purpose of enhancing health promotion or education within Contractor's Service Area(s). Activities may include, but are not limited to, creation and distribution of brochures, pamphlets, newsletters, posters, fliers, web sites, health fairs or sponsorship of health-related events. Contractor may communicate with or involve Providers, caseworkers, community agencies or other interested parties in such activities.

**c.** In determining whether or not Contractor has attempted to influence a DMAP Member's Enrollment as prohibited in this Subsection a, of this section, the method of communication, by itself, shall not constitute a violation. The message and/or content of the communication shall be evidence of the Contractor's intent.

**d.** Contractor shall provide to DMAP, for approval prior to use, the form and content of all materials that reference benefits and/or coverage and Marketing Materials (as defined in OAR 410-141-0000). In the process of reviewing and approving Marketing Material, DMAP will provide for consultation with a medical care advisory committee. Any Contractor representative or agent serving on the advisory committee shall be excused from review of Contractor's materials. Messages strictly for the purpose of health promotion, health education or outreach distributed to Contractor's existing DMAP Members do not require prior approval from DMAP.

**e.** Contractor shall ensure that DMAP Members are not intentionally misled about their options by Contractor's staff, activities or materials. Materials may not contain false, confusing or misleading information. Contractor shall make available copies of all written Marketing Materials to all DHS offices within Contractor's Service Area(s). Statements that will be considered inaccurate, false, or misleading include, but are not limited to, any assertion or statement (whether written or oral) that:

**(1)** The Potential DMAP Member and DMAP 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.

**f.** Contractor shall comply with the information requirements of 42 CFR 438.10 to ensure that, before enrolling, the Potential DMAP Member receives, from the Contractor or the DHS, the accurate oral and written information he or she needs to make an informed decision on whether to enroll with the Contractor.

## EXHIBIT B –Statement of Work – Part IV – Financial Matters

### 1. Financial Risk, Management and Solvency

**a.** Contractor shall demonstrate to DMAP through proof of financial responsibility that it is able to perform the Work required under this Contract efficiently, effectively and economically and is able to comply with the requirements of this Contract. As part of the proof of financial responsibility, Contractor shall provide assurances satisfactory to DMAP that Contractor's provision(s) against the risk of insolvency are adequate to ensure that DMAP Members will not be liable for Contractor's debts if Contractor becomes insolvent. Contractor shall also provide risk protection against catastrophic or unexpected DMAP Member expenses related to Capitated Services for DMAP Members.

**b.** Contractor shall submit to DMAP the following documentation for purposes of determining Contractor's financial responsibility:

**(1)** An annual audit performed by an independent certified public accountant or accounting firm, containing but not limited to the information required in Exhibit G. Contractor shall submit the annual audit to DMAP not later than June 30 following the last day of each calendar year that this Contract is in effect. This provision shall survive for one year following the date of Contract expiration or termination;

**(2)** Quarterly Financial Reports required in Exhibit G. Contractor shall submit the Quarterly Financial Reports to DMAP no later than March 31, May 15, August 15 and November 15 of each year during which this Contract is in effect. This provision shall survive for one year following the date of Contract expiration or termination;

**(3)** Net Worth Reports required to be submitted with Quarterly Financial Reports in Exhibit G. The Net Worth Reports, shall demonstrate that Contractor has maintained a level of net worth that will provide for a minimum adequate operating capital for each quarter consistent with the calculations in Exhibit G. If Contractor fails to meet the required premium to surplus ratio of 20:1, Contractor will be required to retain additional amounts until Contractor has a premium to surplus ratio of 20:1;

**(4)** Provider Capacity Reports shall be submitted no later than March 31 of each year that this Contract is in effect (identifying Contractor Provider panels in place as of January 1 of the Contract Year), as required in Exhibit K. This provision shall survive expiration or termination of this Contract;

**(5)** Utilization reports shall be submitted at the same time as the Quarterly Financial Reports, according to the instructions found in Exhibit G, Report G.4;

**(6)** Evidence of professional and general liability insurance coverage, required under Exhibit F, of this Contract shall be submitted within 30 days of the Contract Effective Date and within 10 days of any change in coverage;

**(7)** Contractor shall notify DMAP of its intent to update or change its data transaction systems that interface with the DHS's data systems or transactions not later than 30 days before making such update or change in order to allow appropriate compatibility testing of any data interfaces with the DHS, if necessary; and

**(8)** Contractor may submit any of the requested documentation electronically, in a format acceptable to DMAP. If any of the information Contractor submits to DMAP that forms the basis for determining the Contractor's financial responsibility is eliminated, changed, or modified in any manner, Contractor shall immediately notify DMAP. Failure to comply with financial responsibility documentation requirements, including solvency protection specified pursuant to the requirements of this Contract, shall be grounds for termination or sanction under this Contract, at DMAP's sole discretion.

**c.** Contractor shall provide solvency protection through maintenance of a restricted reserve account, or other means approved by DMAP, in a manner and amount determined pursuant to the calculation in Exhibit G. The restricted reserve account depository agreement or similar instrument shall be submitted to DMAP, on the Effective Date of this Contract if it has not been submitted prior to the Effective Date, and shall remain in effect throughout the period this Contract is in effect without interruption, except on the written instruction of DMAP.

**(1)** Funds held in the restricted reserves shall be made available to DMAP for the purpose of making payments to Providers in the event of Contractor's insolvency. Insolvency occurs when Contractor is unable to pay debts when due, even if assets exceed liabilities.

**(2)** If any of the information that forms the basis for determining the manner or amount of a restricted reserve account is eliminated, changed, or modified in any manner, Contractor shall immediately notify DMAP.

**(3)** Failure to maintain adequate financial solvency, including solvency protections specified pursuant to the requirements of this Contract, shall be grounds for termination, reduction in Service Area or Enrollment, or sanction under this Contract, at DMAP's sole discretion.

**(4)** Contractor shall submit to DMAP the following documentation of protections against insolvency:

**(a)** Quarterly calculation of restricted reserve amount(s);

**(b)** Restricted reserve Model Depository Agreement(s), surety bond(s) or evidence of a unique Certificate of Authority number issued by DCBS, whichever is required pursuant to Exhibit G of this Contract; and

**(c)** Contractor shall have procedures and policies to assure that DMAP Members will not be liable for any debts or payment of Claims in the event a Subcontractor becomes insolvent. All Subcontracts will include a

clause that the Subcontractor will look only to the Contractor, and under no circumstances to the DMAP Member, for full payment of Claims, and shall further require that this clause survives the termination of this Contract or Subcontract, including breach of contract or subcontract due to insolvency.

**(5)** In the event that insolvency occurs, Contractor remains responsible for providing Covered Services for DMAP Members through the end of the period for which it has been paid and for its hospitalized DMAP Members until discharge.

**(6)** Contractor understands and agrees that in no circumstances will a DMAP Member be held liable for any of the following:

**(a)** The Contractor's or Subcontractors' debt due to Contractor's or Subcontractors' insolvency;

**(b)** Capitated Services authorized or required to be provided under this Contract to the DMAP Member, for which:

**(i)** The State does not pay the Contractor; or

**(ii)** The Contractor does not pay a Provider or Subcontractor that furnishes the services under a contractual, referral, or other arrangement; or

**(c)** Payments for Covered Services furnished under a contract, referral or other arrangement with Contractors, to the extent that those payments are in excess of the amount that the DMAP Member would owe if the Contractor provided the services directly.

Nothing in this Paragraph (6) Item (c), limits Contractor, the DHS, a Provider or Subcontractor from pursuing other legal remedies that will not result in DMAP Member personal liability for such payments.

**d.** Contractor assumes the risk of providing the Capitated Services required under this Contract; except that Contractor shall obtain risk protection against catastrophic and unexpected expenses related to Capitated Services for DMAP Members.

**(1)** The method of protection may include the purchase of catastrophic expense stop-loss coverage or re-insurance by an entity authorized to insure or to reinsure in this State not inconsistent with ORS Ch. 731, and shall be documented at the time of application or within 30 days of signing this Contract.

**(2)** Contractor shall file annual and quarterly reports, as outlined in Exhibit G, DMAP Members Approaching or Surpassing Stop-Loss Deductible using Exhibit G, Report G.2, submitted not later than August 31; in the event of a substantial change in catastrophic claims or change in coverage, Contractor shall update the latest report filed with DMAP within 30 days of such change.

**(3)** If Contractor is regulated by DCBS, Contractor's compliance with re-insurance requirements imposed by DCBS will be deemed to satisfy this requirement. If Contractor is a Federally Qualified Health Maintenance Organization, no catastrophic stop-loss or re-insurance coverage is required.

**e.** Contractor may operate a physician incentive plan only if no specific payment is made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit Medically Appropriate Covered Services furnished to an individual DMAP Member. Contractor shall disclose to DMAP information about Physician Incentive Plans (PIP), which is defined to mean "any compensation to pay a physician or physician group that may directly or indirectly have the effect of reducing or limiting services furnished to a DMAP Member." These Contract requirements implement federal law and regulations to protect DMAP Members against improper clinical decisions made under the influence of strong financial incentives.

**(1)** Contractor shall demonstrate compliance with PIP requirements by reporting to DMAP the information required in Exhibit M. If the calculations required in Exhibit M demonstrate that the Contractor's PIP places physicians or physician groups at substantial risk, as defined in Exhibit M, Contractor shall (1) establish and maintain the level of PIP stop-loss protection required in Exhibit M, and (2) conduct the customer survey.

**(2)** Contractor shall provide to DMAP the information in Exhibit M not later than August 31 of each year this Contract is in effect. If any of the information that forms the basis for determining substantial risk or the amount of stop-loss protection as defined in Exhibit M, is eliminated, changed, or modified in any manner, Contractor shall immediately notify DMAP.

**(3)** At a DMAP Member's request, Contractor shall provide information indicating whether Contractor or any of its Subcontractors use a PIP that may affect the use of referral services, the type of incentive arrangement(s) used, and whether PIP stop-loss protection is provided. If Contractor is required to conduct a customer survey, it must also provide DMAP Member requestors with a summary of survey results.

**(4)** Failure to maintain adequate stop-loss protection or to comply with survey or information requirements in this Contract, including Exhibit M, shall be grounds for termination or sanction under this Contract, at DMAP's sole discretion.

**f.** DMAP may evaluate the adequacy of information provided and the sufficiency, in DMAP's discretion, of the evidence of financial responsibility, solvency and catastrophic protections, and Physician Incentive Plan stop-loss protections obtained by Contractor for purposes of Subsection e, of this section. Contractor agrees to cooperate to make records and knowledgeable personnel available to support or supplement documentation provided for purposes of this section.

**g.** If at any time DMAP believes that Contractor has incorrectly computed the amounts related to these requirements, or that the coverage or protection amounts obtained by Contractor are insufficient to meet these requirements, DMAP may notify Contractor of

changes it requires. Within 30 days of any notice by DMAP under this section, Contractor shall either make the required changes or request an Administrative Review as defined in OAR 410-120-1580(4)-(5). In the event an Administrative Review is requested and pending disposition of that review, DMAP may require that Contractor take such actions as will assure financial responsibility and solvency or PIP stop-loss protections as may be determined necessary.

**2. Dual Payment**

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.

Certain federal laws governing reimbursement of Federally Qualified Health Centers and Rural Health Centers may require DMAP to provide supplemental payments to those entities, even though those entities have subcontracted with Contractor to provide Covered Services. These supplemental payments are outside the scope of this Contract and do not violate the prohibition on dual payment contained herein. Contractor is required to maintain encounter data records and such additional Subcontract information documenting Contractor's reimbursement to Federally Qualified Health Centers and Rural Health Centers, and to provide such information to DMAP upon request.

**3. Claims Payment**

**a.** Contractor may require Participating Providers to submit all billings for DMAP Members to Contractor within four (4) months of the date of service, except under the following circumstances:

**(1)** Billing is delayed due to eligibility issues;

**(2)** Pregnancy of the DMAP Member;

**(3)** Medicare is the primary payer;

**(4)** Cases involving Third Party Resources;

**(5)** Covered Services provided by Non-Participating Providers that are enrolled with DMAP; or

**(6)** Other circumstances in which there are reasonable grounds for delay (which does not include a Subcontractor's failure to verify DMAP Member eligibility).

**b.** Contractor shall have written procedures for processing Claims submitted for payment from any source. The procedures shall specify time frames for and include:

**(1)** Date stamping Claims when received;

**(2)** Determining within a specific number of days from receipt whether a Claim is valid or non-valid;

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

**(4)** The specific number of days following receipt of additional information that a determination must be made;

**(5)** Sending notice of the decision with Appeal rights to the DMAP Member when the determination is made to deny the Claim;

**(6)** Making Appeal rights available upon request to a DMAP Member's authorized Representative who may be either a Participating Provider or a Non-participating Provider when the determination is made to deny a Claim for payment; and

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

**c.** Contractor shall pay or deny at least 90% of Valid Claims within forty-five (45) days of receipt and at least 99% of Valid Claims within sixty (60) days of receipt. Contractors shall make an initial determination on 99% of all Claims submitted within sixty (60) days of receipt.

**d.** Claims that are subject to payment under this Contract by Contractor from Non-Participating Providers who are enrolled with DMAP will be billed to Contractor consistent with the requirements of OAR 410-120-1280, Billing, and OAR 410-120-1300, Timely Submission of Claims. If a Provider is not enrolled with DMAP on the date of service, but the Provider becomes enrolled pursuant to OAR 410-120-1260(6), Provider Enrollment, the Claim shall be processed by Contractor as a Claim from a Non-Participating Provider. Payment of Non-Participating Providers shall be consistent with the provisions of OAR 410-120-1340, Payment.

# EXHIBIT B –Statement of Work – Part V – Operations

## 1. Record Keeping

### a. Clinical Records

Contractor shall maintain a medical record keeping system adequate to fully disclose and document the medical condition of the DMAP Member and the extent of Medical Case Management Services and Capitated Services received by DMAP Members.

Clinical records shall be retained 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, the Clinical Records must be retained until all issues arising out of the action are resolved.

### b. Financial Records

Contractor shall maintain sound financial management and generate periodic financial reports and make them available to DMAP consistent with requirements of OAR 410-141-0340, OHP Prepaid Health Plan Financial Solvency, and the requirements of Exhibit G (Solvency Plan Financial Reporting), Exhibit K (Provider Capacity Report), and Exhibit M (Physician Incentive Plan Regulation Guidance).

Financial records, supporting documents, statistical records, and all other records pertinent to this Contract shall be retained by Contractor for a period of three years from the date of submission of the final Claims for payment. If any litigation, Claim, financial management review or audit is started before the expiration of the 3-year period, the records shall be retained until all litigation, Claims or audit findings involving the records have been resolved and final action taken.

### c. Client Process Monitoring System (CPMS) Data

The Client Process Monitoring System is a vital monitoring tool used by AMH to provide documentation that DMAP Members received Chemical Dependency Services and to provide data on access and service delivery of Chemical Dependency Services under Exhibit B, Part I, Section 14. Contractor shall provide, and shall include a provision in its contracts with Subcontractors for Chemical Dependency Services that the Subcontractors shall provide, to AMH within 30 days of DMAP Member admission or discharge all the information required by AMH's most current publication of "Client Process Monitoring System."

### d. HIPAA Security, Data Transactions Systems and Privacy Compliance

For the provision of Capitated Services under this Contract, Contractor is a "Covered Entity" for purposes of the Health Insurance Portability and Accountability Act, 42 USC § 1320-d et seq., and the federal regulations implementing the Act (collectively referred to as "HIPAA"). Contractor shall develop and implement such policies and procedures for maintaining the privacy and security of records and authorizing the use and disclosure of records required to comply with this Contract and with HIPAA.

**(1)** Data transactions systems: Contractor shall comply with the HIPAA standards for electronic transactions published in 45 CFR Part 162 and the DHS EDI Rules, OAR 410-001-000 through 410-001-0200.

**(2)** Privacy: Contractor, its agents, employees and Subcontractors shall ensure that Individually Identifiable Health Information (IIHI) of DMAP Members is protected from unauthorized use or disclosure consistent with the requirements of the HIPAA Privacy Rules in 45 CFR Parts 160 and 164 and as defined in Exhibit D, Section 13, Access to Records and Facilities, Subsections a. and b.

**(3)** HIPAA Information Security. All information in any format about a DMAP Member obtained by Contractor or its officers, employees, Subcontractors or agents in the performance of the Work under this Contract, including information obtained in the course of providing services, shall be defined as "DMAP Member Information". Contractor shall adopt and employ reasonable administrative and physical safeguards consistent with the Security Rules in 45 CFR Part 164 to ensure that DMAP Member Information shall be used by or disclosed only to the extent necessary for the permitted use or disclosure and consistent with applicable State and federal laws and the terms and conditions of this Contract. Security incidents involving DMAP Member Information must be immediately reported to DHS' Privacy Officer.

**(4)** Contractor shall require each Physician to have a unique provider identification number that complies with 42 USC 1320d-2(b).

## 2. Executive Compensation Reporting

The Parties shall amend this Contract to add requirements for reporting the three highest executive salary and benefit packages of Contractor, to comply with ORS 414.725(1)(d) and (e), enacted by House Bill 2952 (Chapter 458, 2007 Laws).

## 3. Encounter and Pharmacy Data

Encounter and pharmacy data collection are two methods that DMAP has established to provide verification that services were actually provided to Contractor's DMAP Members.

**a.** Encounter Data are records of health care services that have been provided to DMAP Members in exchange for Capitation Payments. An "Encounter" is a service or bundle of services provided to one DMAP Member by one medical service Provider (whether a Contractor employee or Subcontractor or Non-Participating Provider for which Contractor is responsible for payment) in one time period.

**b.** Pharmacy Data are records of health services, which include pharmaceutical drugs and biologics that have been delivered or administered to DMAP Members in exchange for Capitation Payments.

**c.** Contractor shall submit Encounter Data to DMAP on a monthly basis pursuant to the requirements of Exhibit H, Encounter Data Minimum Data Set Requirements and Corrective Action.

**d.** Contractor shall submit Pharmacy Data to DMAP on a monthly basis pursuant to the requirements of Schedule 4, Pharmacy Data Requirements and Corrective Action. Contractor shall submit Pharmacy Expense Reports pursuant to the specifications in Schedule 3, Pharmacy Expense Reports.

**e.** Accuracy, completeness and timeliness of data submissions and resubmissions, as well as availability of supporting medical records required in Exhibit H, and Schedule 4 are material requirements of this Contract. Failure to comply with these requirements may result in Corrective Action and/or such other Sanctions as DMAP may impose under Exhibit B, Part VI, Section 2 of this Contract.

**f.** The Encounter Data reporting requirements measure the provision of health care and services during a time period in which Contractor was providing OHP Capitated Services. The Encounter Data reporting requirements expressly survive the expiration or termination of this Contract. Termination of this Contract, modification or reduction of the Contractor's Service Area does not relieve Contractor of its obligation to submit all required Encounter Data for dates of service applicable to Contractor's Service Areas while they were paid a Capitation Payment under this Contract, nor does it relieve Contractor of the obligation to complete Corrective Action plans or pay recovery costs related to Encounter Data obligations under Exhibit B, Part VI, Section 2 of this Contract.

**g.** The Pharmacy Data reporting requirements measure the provision of pharmaceutical drugs and biologics during a time period in which Contractor was providing OHP Capitated Services. The Pharmacy Data reporting requirements

expressly survive the expiration or termination of this Contract. Termination or expiration of this Contract, modification or reduction of the Contractor's Service Area does not relieve Contractor of its obligation to submit all required Pharmacy Data for dates of service applicable to Contractor's Service Areas while they were paid a Capitation Payment under this Contract, nor does it relieve Contractor of the obligation to complete Corrective Action plans or pay recovery costs related to Pharmacy Data obligations under Exhibit B, Part II, Section 2, of this Contract.

**h. Data Certification and Validation.**

Contractor shall comply with the requirements described in Exhibit H, Data Certification and Validation. The requirements include, but are not limited to:

**(1)** Completion and required updates of the H.2 Signature Authorization Form;

**(2)** Concurrent submission of the H.3 Data Certification and Validation Report Form with each Encounter Data or Pharmacy Transaction submission; and

**(3)** Completion of the H.4 Claim Count Validation Acknowledgement and Action Form as indicated pursuant to the instructions in Exhibit H.

A H.3 Data Certification and Validation Report Form submitted to DMAP that omits required information will not meet the requirements of Certified and Validated Data and will not be accepted by DMAP.

Failure by Contractor to comply with the requirements in Exhibit H will result in Corrective Action and/or such other remedies or sanctions as DMAP may impose under Exhibit B, Part II, Section 2, of this Contract.

When Corrective Action has been initiated by DMAP, Contractor may submit documentation to DMAP citing specific circumstances which delay Contractor's timely submittal of the Data Certification and Validation Forms or Claim Count Verification Acknowledgment and Action Forms. DMAP will review the documentation and make a determination within ten (10) Business Days on whether the circumstances cited are Acceptable.

**4. (Reserved)**

## EXHIBIT B –Statement of Work – Part VI – Relationship of Parties

### 1. DMAP Compliance Review

DMAP is authorized to monitor compliance with the requirements in the Statement of Work. Methods of monitoring compliance may include review of documentation submitted by Contractor, Contract performance review, Complaints, on-site review of documentation or any other source of relevant information. Contractor agrees to cooperate to make records and facilities available for compliance review, consistent with Exhibit D, Section 13 of this Contract. If compliance cannot be determined, or if DMAP determines that Contractor is non-compliant with the requirements of the Contract, DMAP may find Contractor has breached Contract requirements and may impose Sanctions under Exhibit B, Part VI, Section 2, of this Contract, and pursue other remedies available under this Contract.

### 2. Sanctions

**a.** DMAP may impose sanctions, as specified in Subsection b. of this section, if it determines that Contractor has acted or failed to act as described in this Subsection a. DMAP's determination may be based on findings from an onsite survey, DMAP Member or other complaints, financial status or any other source. Conditions that may result in a Sanction under this section may include when Contractor acts or fails to act as follows:

**(1)** Fails substantially to provide Medically Appropriate services that the Contractor is required to provide, under law or under its Contract with DMAP, to a DMAP Member covered under this Contract;

**(2)** Imposes on DMAP Members premiums or charges that are in excess of the premiums or charges permitted under the Oregon Medical Assistance Program;

**(3)** Acts to discriminate among DMAP Members on the basis of their health status or need for health care services. This includes, but is not limited to, termination of Enrollment or refusal to reenroll a DMAP Member, except as permitted under the Oregon Medical Assistance Program, or any practice that would reasonably be expected to discourage Enrollment by individuals whose medical condition or history indicates probable need for substantial future medical services;

**(4)** Misrepresents or falsifies any information that it furnishes to CMS or to the State, or its designees, including but not limited to the assurances submitted with its application or Enrollment, any certification, any report required to be submitted under this Contract, encounter data or other information relating to care or services provided to a DMAP Member;

**(5)** Misrepresents or falsifies information that it furnishes to a DMAP Member, Potential DMAP Member, or health care Provider;

**(6)** Fails to comply with the requirements for Physician Incentive Plans, as set forth in 42 CFR 422.208 and 422.210, and this Contract;

**(7)** Fails to maintain a Participating Provider Panel sufficient to ensure adequate capacity to provide Covered Services under this Contract;

**(8)** Fails to maintain an internal quality improvement program, or fraud and abuse prevention program, or to provide timely reports and data required under Exhibit B, Part I through Part VI, of this Contract;

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

**(10)** Fails to pay for Emergency Services and post-emergency stabilization services or Urgent Care Services required under this Contract;

**(11)** Fails to follow accounting principles or accounting standards or cost principles required by Federal or State laws, rule or regulation, or this Contract;

**(12)** Fails to make timely Claims payment to Providers or fails to provide timely approval of authorization requests;

**(13)** Fails to disclose required ownership information or fails to supply requested information to DMAP on Subcontractors and suppliers of goods and services;

**(14)** Fails to submit accurate, complete, and truthful Encounter Data in the time and manner required by Exhibit H, "Encounter Data Minimum Data Set Requirements and Corrective Action", Schedule 4, "Pharmacy Data Requirements and Corrective Action" and Exhibit H, Form H.3 "Data Certification and Validation;"

**(15)** Contractor distributes directly or indirectly through any agent or independent contractor, marketing materials that have not been approved by the State or that contain false or materially misleading information;

**(16)** Contractor fails to comply with a term or condition of this Contract, whether by default or breach of this Contract. Imposition of a sanction for default or breach of this Contract does not limit DMAP's other available remedies;

**(17)** Fails to submit accurate, complete and truthful Pharmacy Data in the time and manner required by Schedule 3 "Pharmacy Expense Reports", Schedule 4, "Pharmacy Data Requirements and Corrective Action" and Exhibit H, Form H.3 "Data Certification and Validation;" or

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

**b.** Sanctions that may be imposed include but are not limited to the following sanctions. The use of one sanction by DMAP does not preclude the imposition of any other sanction or combination of sanctions or any other remedy authorized under this Contract for the same deficiencies. DMAP may:

**(1)** Assess a Recovery Amount in the amounts authorized in 42 USC 1396u-2(e)(2);

**(2)** Assess a Recovery Amount equal to one percent (1%) of Contractor's last monthly Capitation Payment immediately prior to imposition of the sanction, to be deducted from Contractor's next monthly Capitation Payment after imposition of sanction, except when a Recovery Amount has been assessed under Paragraph (1) of this subsection;

**(3)** Grant DMAP Members the right to Disenroll without cause (DMAP may notify the affected DMAP Members of their right to Disenroll);

**(4)** Suspend all new Enrollment, including default Enrollment, or reduce the Enrollment level and/or the number of Contractor's current DMAP Members after the effective date of the sanction;

**(5)** Suspend payment for DMAP Members enrolled after the effective date of the sanction until DMAP is satisfied that the reasons for imposition of the sanction no longer exists and is not likely to recur;

**(6)** Require Contractor to develop and implement a plan that is acceptable to DMAP for correcting the problem.

**(a)** At a minimum, the Corrective Action Plan must include:

**(i)** A written standard of conduct to be implemented by the Contractor that corrects the specific areas of non-compliance and how that standard of conduct will be established and maintained within Contractor's and Subcontractor's (as applicable) organization; and

**(ii)** Designation of the person with authority within Contractor's organization charged with the responsibility of accomplishing and monitoring compliance.

**(b)** If Contractor has not submitted a Corrective Action Plan that is acceptable to DMAP within the specified time period or does not implement or complete the Corrective Action within the specified time period, DMAP will proceed with other sanctions or with termination of this Contract.

**(7)** If DMAP determines that there is continued egregious behavior that is described in Exhibit B, Part II, Section 2, Subsection a., of this Contract; or that there is substantial risk to DMAP Members' health; or that action is necessary to ensure the health of DMAP Members while improvements are made to remedy violations or until there is an orderly termination or reorganization by Contractor:

**(a)** DMAP must require Contractor to implement temporary management mechanisms, such as employment of consultants or other individuals or entities approved by DMAP for the purpose, at Contractor's expense;

**(b)** DMAP must grant DMAP Members the right to Disenroll without cause and notify DMAP Members of the right to disenroll without cause;

**(c)** DMAP must not delay the imposition of temporary management mechanisms to provide for Administrative Review before imposing this sanction; and

**(d)** DMAP must not terminate temporary management mechanisms until it determines that Contractor can ensure that the sanctioned behavior will not recur.

**(8)** Deny payments under this Contract for new DMAP Members when, and for so long as, payment for those DMAP Members is denied by CMS in accordance with 42 CFR 438.730; or

**(9)** Any other sanctions reasonably designed to remedy and/or compel future compliance with this Contract.

**c.** DMAP will notify the Contractor in writing of its intent to impose a sanction. The notification shall explain the factual basis for the sanction, reference to the section(s) of this Contract or federal or State law or regulation that has been violated, explain the actions expected of Contractor, and state the Contractor's right to file a request for Administrative Review with the Director of DMAP in writing within 30 days of the date of the sanction notice. Notwithstanding the preceding provision of this Subsection c., in cases in which DMAP determines that conditions could compromise a DMAP Member's health or safety or when DMAP acts pursuant to Subsection b, Paragraph (7) of this section, DMAP may provisionally impose the sanction before such Administrative Review opportunity is provided.

**(1)** Contractor shall make Recovery Amount payments in full to DMAP within 30 days of the date of the sanction notice, unless Contractor has made a timely request for Administrative Review pursuant to this Subsection c. above in which case Contractor may withhold payment of a disputed amount pending the issuance of the Administrative Review decision. Absent a timely request for Administrative Review, if Contractor fails to make payment within 30 days of the sanction notice, DMAP will recoup the recovery payment from Contractor's future Capitation Payment(s) or as otherwise provided under this Contract, until the Recovery Amount payment is satisfied.

**(2)** The Administrative Review process described in Subsections b, Paragraph (7) of this section and this Subsection c, will be conducted in the same manner described in OAR 410-120-1580(4)-(6). Contractor understands and agrees that Administrative Review is the sole avenue for review of sanction decisions under this Exhibit B, Part II, Section 2, of this Contract.

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

DMAP will give CMS' Regional Office written notice whenever Contractor has a sanction imposed or lifted by DMAP for one of the violations listed in this Section 2, Subsection a, Paragraphs (1) through (6) or Paragraph (15). DMAP may, at DMAP's discretion, give CMS' Regional Office written notice whenever Contractor has a sanction imposed or lifted by DMAP for any breach or violation of this Contract requirement excluding those specifically noted above.

# EXHIBIT C – Consideration

## 1. Payment Types and Rates

In consideration of all the Work to be performed under this Contract, the DHS will pay Contractor a monthly Capitation Payment for each DMAP Member, beginning with the date of Enrollment and ending with the date of Disenrollment, for those DMAP Members who are enrolled with Contractor according to DHS records. The monthly Capitation Payment rate authorized for each DMAP Member in the Rate Group identified in this Exhibit, Attachment 2, Capitation Rates, is that amount indicated in this Exhibit, Attachment 2, for that particular Rate Group as "Total Services with Admin." Where the date of a DMAP Member's Enrollment or Disenrollment is during mid-month, the Capitation Payment for that DMAP Member shall be prorated.

**a.** The general description of the actuarial basis for calculating Capitation Payments is described in Exhibit C, Attachment 1, Calculation of Capitation Payment Rates.

The Covered Services described in Exhibit B, Part I, Section 2 have been divided into categories of services. Categories of service describe but do not replace or supercede the scope of Covered Services described in Exhibit B, Part I through Part VI; categories of services are used to develop Capitation Payment rates as described in Exhibit C, Attachment 2.

**(1) Mandatory Categories of Services.**

**(a)** For purposes of developing Capitation Rates, the following service categories constitute the mandatory categories of Covered Services for DMAP Members eligible for the Plus Benefit Package:

Physician- Basic includes Somatic Mental Health, and Vaccines for Children;
Physician - Family Planning;
Physician – Hysterectomy;
Physician – Maternity;
Physician – Newborn;
Physician - Other includes Dialysis, Hearing Services PT/OT Services, Speech/Language Pathology, etc.;
Outpatient Hospital/ASC - Basic includes Emergency Room;
Outpatient Hospital/ASC - Family Planning;
Outpatient Hospital/ASC – Maternity;
Outpatient Hospital/ASC – Sterilization;
Outpatient Hospital/ASC – Hysterectomy;
Prescription Drugs – Basic;
Prescription Drugs - Family Planning;
Inpatient Hospital - Basic includes Acute Detoxification;
Inpatient Hospital – Hysterectomy;
Inpatient Hospital - Family Planning;
Inpatient Hospital – Maternity;
Inpatient Hospital – Newborn;
Inpatient Hospital – Sterilization;
Chemical Dependency Services, Outpatient Treatment Services, Methadone/LAAM dosing and dispensing;
Diagnostic Services/Lab/X-Ray;
DME/Medical Supplies/Hearing Aids & Supplies;

Exceptional Needs Care Coordination;
Home Health/Private Duty Nursing/Hospice;
Post Hospital Extended Care;
Tobacco Cessation;
Transportation – Ambulance; and
Vision Exams, Therapy, Materials

**(b)** For purposes of developing Capitation Rates, the following service categories constitute the categories of Covered Services for DMAP Members eligible for the Standard Benefit Package:

Physician- Basic includes Somatic Mental Health and Vaccines for Children;
Physician - Family Planning;
Physician – Hysterectomy;
Physician - Other includes Dialysis, Hearing Services PT/OT Services, Speech/Language Pathology, etc.;
Outpatient Hospital/ASC - Basic includes Emergency Room;
Outpatient Hospital/ASC - Family Planning;
Outpatient Hospital/ ASC – Maternity;
Outpatient Hospital/ASC – Sterilization;
Outpatient Hospital/ASC – Hysterectomy;
Prescription Drugs;
Inpatient Hospital - Basic includes Acute Detoxification;
Inpatient Hospital – Hysterectomy;
Inpatient Hospital - Family Planning;
Inpatient Hospital – Maternity;
Inpatient Hospital – Sterilization;
Chemical Dependency Services, Outpatient Treatment Services, Methadone/LAAM dosing and dispensing;
Diagnostic Services/Lab/X-Ray;
DME (limited, on-going, not a one-time basis);
Exceptional Needs Care Coordination;
Home Health/Private Duty Nursing/Hospice;
Post Hospital Extended Care;
Tobacco Cessation; and
Transportation - Ambulance

The Standard Benefit Package may exclude or limit some benefits in the above listed service categories as described in the following rules:

**(i)** OAR 410-120-1210, Medical Assistance Benefit Packages and Delivery System;

**(ii)** OAR 410-122-0055, Standard Benefit Package Limitations;

**(iii)** OAR 410-125-0047, Limited Hospital Benefit Package for OHP Standard Population;

**(iv)** OAR 410-125-0080, Inpatient Services;

**(v)** OAR 410-127-0055, OHP Standard Benefit Package;

**(vi)** OAR 410-129-0195, Standard Benefit Package;

**(vii)** OAR 410-130-0163, Standard Benefit Package;

**(viii)** OAR 410-131-0275, Standard Benefit Package;

**(ix)** OAR 410-132-0055, OHP Standard Benefit Package;

**(x)** OAR 410-140-0115, Standard Benefit Package;

**(xi)** OAR 410-141-0480,Oregon Health Plan Benefit Package of Covered Services; and

**(xii)** OAR 410-148-0090, Standard Benefit Package.

If DMAP notifies Contractor of a significant change to the OHP Standard Benefit Package, Contractor may discontinue providing the Covered Services available through the Standard Benefit Package in all Service Areas. Before Discontinuation of these Covered Services to DMAP Members in the Standard Benefit Package, Contractor must provide DMAP with a written notice of Contractor's intent to discontinue the provision of these Covered Services. The written notice must be provided to DMAP at least 30 days prior to DMAP's End of the Month Deadline and Enrollment Dates or a specified time period mutually agreed to by DMAP and Contractor. Discontinuation of OHP Standard Benefit Package Covered Services will not take effect until the DHS and Contractor execute a Contract Amendment pursuant to Exhibit D, Section 18 of this Contract.

For specific details on DMAP's End of the Month Deadline and Enrollment Dates schedule contact the DMAP PHP Coordinator.

**(2) Optional Categories of Services.**

The only optional category of service available to Contractor is Maternity Case Management (MCM). Because the Contractor has not agreed to provide Maternity Case Management Services, this Contract does not include Maternity Case Management as a Covered Service.

**(3)** The Capitation Payments calculations result in a specific capitation rate schedule applicable to this Contract, attached hereto and incorporated herein as Exhibit C, Attachment 2, Capitation Rates.

**(4)** If Contractor has a contractual relationship with a designated Type A, Type B, or rural critical access hospital, the Contractor and each said hospital shall provide representations and warranties to DMAP:

**(a)** That said contract establishes the total reimbursement for the services provided to persons whose medical assistance benefits are administered by the Contractor; and

**(b)** That hospital reimbursed under the terms of said contract is not entitled to any additional reimbursement from DMAP for services provided to persons whose medical assistance benefits are administered by Contractor.

## 2. Payment in Full

The Capitation Payment rate indicated in Attachment 2, to this Exhibit for each Rate Group as "Total Services with Admin." is the rate authorized to be payable to the Contractor from the DHS per DMAP Member in the applicable Rate Group for all Work provided under this Contract.

## 3. Changes in Payment Rates

The Capitation Payment rate established in Attachment 2, to this Exhibit may be changed only by amendment to this Contract pursuant to Exhibit D, Section 18 of this Contract.

**a.** Changes in the Capitation Payment rate as a result of adjustments to the Service Area and/or to the Enrollment limit may be required pursuant to Exhibit B, Part II, Section 2 of this Contract.

**b.** The Capitation Payments authorized to be paid under this Contract are based on the funded condition-treatment pairs on the Prioritized List of Health Services contained in OAR 410-141-0520 in effect on the date this Contract is executed, subject to the terms of this Contract.

**(1)** Pursuant to ORS 414.720, the Prioritized List of condition-treatment pairs developed by the Health Services Commission may be expanded, limited or otherwise changed. Pursuant to ORS 414.715 and 414.735, the funding line for the services on the Prioritized List may be changed by the Legislature.

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

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

**(4)** In addition, the DHS will notify Contractor at least two weeks prior to any legislative consideration of such reductions.

**(5)** Adjustments made to the Covered Services pursuant to ORS 414.735 during this Contract Year will be referred to the actuary who is under Contract with DMAP for the determination of capitation rates. The actuary will determine any rate modifications required as the result of cumulative adjustments to the funded list of Covered Services based on the totality of the OHP rates for all Contractors (total OHP rates).

**(a)** For changes made during the first year of the two year per capita cost period since the list was last approved by the Legislative Assembly or the Emergency Board, the actuary will consider whether changes are covered by the trend rate included in the existing total OHP capitation rate(s) and, thus, not subject to adjustment or are services moved from a non-covered service to a Covered Service.

**(b)** If the net result under paragraph (e) or (e) (1) above for services subject to the adjustment is less than 1% of the total OHP rates, no adjustment to the Capitation Payment rate(s) in Attachment 2, to this Exhibit will be made.

**(c)** If the net result under paragraph (e) or (e) (1) above is 1% or greater of the total OHP rates, the Capitation Payment rate(s) in Attachment 2, to this Exhibit will be amended pursuant to Exhibit D, Section 18 of this Contract.

**(d)** The assumptions and methodologies used by the actuary to determine whether the net result is more or less than 1% shall be made available to Contractor.

**(6)** Any reductions made in Covered Services under ORS 414.735 shall take effect no sooner than 60 days following final legislative action approving the reductions. Any reductions in Covered Services or Capitation Payment rates shall be made by amendment to this Contract.

**(7)** Contractor shall be responsible for all federal and State taxes applicable to compensation or payment paid to Contractor under this Contract and, unless Contractor is subject to backup withholdings, DHS will not withhold from such compensation or payments any amount(s) to cover Contractor's federal or State tax obligations.

**(8)** Contractor is not eligible for any Social Security unemployment insurance, workers' compensation, or Public Employees' Retirement System, benefits from compensation or payments paid to Contractor under this Contract.

## 4. Timing of Capitation Payments

**a.** The date on which DHS will process Capitation Payments for Contractor's DMAP Members depends on whether the DMAP Enrollment occurred during a weekly or monthly Enrollment cycle. DMAP/DSU will provide a schedule of enrollment end of month deadlines for each month of the Contract period. On months where the first of the month falls on a Friday, Saturday or Sunday, Capitation Payments will be made available to the Contractor no later than the 11th day of the month to which such payments are applicable.

**(1)** Weekly Enrollment: For DMAP Members enrolled with Contractor during a weekly Enrollment cycle, Capitation Payments will be made available to Contractor no later than two weeks following the date of Enrollment, except for those occurrences each year when the weekly and monthly Enrollment start date are the same day.

**(2)** Monthly Enrollment: For DMAP Members enrolled with Contractor during a monthly Enrollment cycle, Capitation Payments shall be made available to Contractor by the 10th day of the month to which such payments are applicable, except for those occurrences each year when the weekly and monthly Capitation Payments coincide with each other.

**b.** Both sets of payments described in Subsection a, of this section shall appear on the monthly Payment/Remittance Advice. To assist Contractor with Enrollment and Capitation Payment/Remittance Advice reconciliation, DHS will include in the Enrollment Transaction the original adjustment amount and the Capitation/Premium paid amount for each of Contractor's enrolled DMAP Members. The inclusion of this information does not ensure or suggest that the two transaction files will balance. If Contractor believes that there are any errors in the Enrollment information, Contractor shall notify DMAP by contacting their designated DMAP PHP Coordinator. Contractor may request an adjustment to the Remittance Advice no later than 18 months from the affected Enrollment period.

**c.** DMAP will make retroactive Capitation Premium/Payments to Contractor for any DMAP Member(s) erroneously omitted from the Enrollment transaction files. Such payments will be made to Contractor once DMAP manually processes the correction(s).

**d.** DMAP will make retroactive Capitation Premium/Payments to Contractor for newborn DMAP Members enrolled with Contractor. Such payments will be made to Contractor by the 10th day of the month after DMAP adds the newborn(s).

**e.** Services that are not Capitated Services provided to a DMAP Member or for any health care services provided to OHP Clients who are not enrolled with Contractor are not entitled to be paid as Capitated Premium/Payments. Fee-for-service Claims for payment must be billed directly to DMAP by Contractor, its Subcontractors, or its Participating Providers, all of which must be enrolled with DMAP in order to receive payment. Billing and payment of all fee-for-service Claims shall be pursuant to and under DMAP General Rules (Division 120).

## 5. Settlement of Accounts

**a.** If a DMAP Member is Disenrolled, any Capitation Payments received by Contractor after the effective date of Disenrollment will be considered an overpayment and will be recouped by DMAP from future Capitation Payments.

**b.** DMAP will have no obligation to make any payments to Contractor for any period(s) during which Contractor fails to carry out any of the terms of this Contract.

**c.** If Contractor requests, or is required by DMAP, to adjust the Service Area or Enrollment limit or to transfer or reassign DMAP Members due to loss of Provider capacity or for other reasons, any delay in executing amendments or completing other Contract obligations pursuant to Exhibit B, Part II, Section 2, Adjustments in Service Area or Enrollment, may result in recovery of Capitation Payments to which Contractor was not entitled under the terms of this Contract.

**d.** Any payments received by Contractor from DMAP or the DHS under this Contract, and any other payments received by Contractor from DMAP or the DHS, or any other source to which Contractor is not entitled under the terms of this Contract shall be considered an overpayment and shall be recovered from Contractor.

**e.** Sanctions imposed that result in Recovery Amounts pursuant to Exhibit B, Part VI, Section 2 of this Contract are subject to recovery and shall be recovered from Contractor.

**f.** Any overpayment and/or Recovery Amount under Exhibit B, Part II, Section 2 of this Contract may be recovered by recoupment from any future payments to which Contractor would be entitled from DMAP or the DHS, or pursuant to the terms of a written agreement with DMAP, or by civil action to recover the amount. DMAP may withhold payments to Contractor for amounts disputed in good faith and shall not be charged interest on any payments so withheld.

**g.** DMAP will recover from Contractor payments made to Contractor or to other Providers for sterilizations and hysterectomies performed where the Contractor failed to meet the requirements of Exhibit B, Part I, Section 11, of this Contract, the amount of which will be calculated as follows:

**1.** Contractor shall, within 60 days of a request from DMAP, provide DMAP with a list of all DMAP Members who received sterilizations or hysterectomies, or prior authorization of sterilizations or hysterectomies, from Contractor or its Subcontractors during the Contract Year and copies of the informed consent form or certification. DMAP will be permitted to review the medical records of these DMAP Members and any other DMAP Members enrolled during the Contract Year, selected by DMAP for purposes of determining whether Contractor complied with OAR 410-130-0580.

**2.** By review of the informed consent forms, certifications, and other relevant medical records of DMAP Members, DMAP will determine for the Contract Year the number of sterilizations and hysterectomies provided or authorized by Contractor or its Subcontractors that did not meet the requirements of Exhibit B, Part I, Section 11, of this Contract.

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

**4.** The number of vasectomy, tubal ligation, and hysterectomy procedures that do not meet the documentation requirements of Exhibit B, Part I, Section 11, of this Contract, shall be multiplied by the assigned "value of service".

**5.** "Value of service" for vasectomy, tubal ligation, and hysterectomy means the OHP amount calculated by DMAP's actuarial contractor for each category of service using the Encounter Data.

**6.** The results of Pargraph (4) of this subsection will be totaled to determine Contractor's overpayment for hysterectomies and sterilizations subject to recovery pursuant to Exhibit C, Section 5, Subsection f, of this Contract.

**7.** The final results of the review will be conveyed to Contractor in a timely manner within ninety (90) days of determination.

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

## EXHIBIT C – Consideration - Attachment 1 – Calculation of Capitation Payments

### Capitation Rate Methodology

DHS has developed actuarially set Adjusted Per Capita Costs (Capitation Rates) to reimburse plans for providing the Covered Services. A full description of the methodology used to calculate per capita costs may be found in the PricewaterhouseCoopers (PwC) document *Analysis of Federal Fiscal Years 2008-2009 Average Costs*, dated September 22, 2006, which is by this reference incorporated herein. A full description of the methodology used to calculate Capitation Rates for the Plus Benefit Package and Standard Benefit Package may be found in the PwC document *Oregon Health Plan Medicaid Demonstration Capitation Rate Development, January 2008-December 2008,* dated November 2007, which is by this reference incorporated herein.

# EXHIBIT C – Consideration - Attachment 2 – Capitation Rates

# EXHIBIT D – Standard Terms and Conditions

## 1. Controlling State Law/Venue

This Contract shall be governed and construed in accordance with the laws of the State of Oregon. Any action or suit involving this Contract shall be filed and tried in Marion County, Oregon; provided, however, that if a claim must be brought in a federal forum, then it shall be conducted solely and exclusively within the United States District Court for the District of Oregon. In no event shall this provision be construed as a waiver of the State's sovereign immunity. Contractor, by execution of this Contract, hereby consents to the in personam jurisdiction of said courts.

## 2. Compliance with Applicable Laws and Rules

**a.** Contractor shall comply and cause all Subcontractors to comply with all State and local laws, rules, and regulations applicable to the Contract or to the performance of Work as they may be adopted or amended from time to time, including but not limited to the following: (i) ORS Chapter 659A.142; (ii) all other applicable requirements of State civil rights and rehabilitation statutes, rules and regulations; (iii) DHS rules pertaining to the provision of prepaid capitated health care and services, OAR Chapter 410, Division 141; and (iv) all other DHS Rules in OAR Chapter 410. These laws, rules, and regulations, are incorporated by reference herein to the extent that they are applicable to this Contract and required by law to be so incorporated. DHS' performance under this Contract is conditioned upon Contractor's compliance with the provisions of ORS 279B.220, 279B.225, 279B.230, 279B.235 and 279B.270, which are incorporated by reference herein. Contractor shall, to the maximum extent economically feasible in the performance of this Contract, use recycled paper (as defined in ORS 279A.010(1)(ee)), recycled PETE products (as defined in ORS 279A.010(1)(ff)), and other recycled products (as "recycled product" is defined in ORS 279A.010(1)(gg)).

**b.** In compliance with the Americans with Disabilities Act, any written material that is generated and provided by Contractor under this Contract to DHS clients, including Medicaid-Eligible Individuals, shall, at the request of such DHS clients, be reproduced in alternate formats of communication, to include Braille, large print, audiotape, oral presentation, and electronic format. DHS shall not reimburse Contractor for costs incurred in complying with this provision. Contractor shall cause all Subcontractors under this Contract to comply with the requirements of this provision.

**c.** Contractor shall comply with the federal laws, rules and executive orders, as set forth or incorporated, or both, in this Contract and all other federal laws, rules and executive orders, applicable to Contractor's performance under this Contract as they may be adopted, or amended from time to time.

## 3. Independent Contractor

The parties agree and acknowledge that their relationship is that of independent contracting parties and that Contractor is not an officer, employee, or agent of the State of Oregon as those terms are used in ORS 30.265 or otherwise.

## 4. Representations and Warranties

**a.** Contractor's Representations and Warranties: Contractor represents and warrants to DHS that:

**(1)** Contractor has the power and authority to enter into and perform this Contract,

**(2)** this Contract, when executed and delivered, shall be a valid and binding obligation of Contractor enforceable in accordance with its terms,

**(3)** Contractor has the skill and knowledge possessed by well-informed members of its industry, trade or profession and Contractor will apply that skill and knowledge with care and diligence to perform the Work in a professional manner and in accordance with standards prevalent in Contractor's industry, trade or profession,

**(4)** Contractor shall, at all times during the term of this Contract, be qualified, professionally competent, and duly licensed to perform the Work, and

**(5)** Contractor prepared its application related to this Contract, if any, independently from all other applicants, and without collusion, fraud, or other dishonesty.

**b.** Warranties cumulative: The warranties set forth in this section are in addition to, and not in lieu of, any other warranties provided.

## 5. Funds Available and Authorized

DMAP certifies at the time this Contract is signed that sufficient funds are available and authorized for expenditure to finance costs of this Contract within DMAP's current appropriation or limitation. However, continuation of this Contract, or any extension, after the end of the biennium in which this Contract is signed, is contingent upon DMAP receiving sufficient appropriations, limitations, or other expenditure authority to make payments as required under this Contract. In the event the Oregon Legislative Assembly fails to approve sufficient appropriations, limitations, or other expenditure authority for the succeeding biennium, DMAP may terminate this Contract effective upon written notice to Contractor with no further liability to Contractor.

## 6. Changes/Ownership

**a.** Contractor shall notify DMAP of any changes in the ownership of Contractor and provide DMAP 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 455.104. If Contractor changes address, licensure status as a health plan with DCBS or as a Medicare Advantage plan, or Federal Tax Identification Number (TIN), Contractor shall notify DMAP within 30 days of the changes. Failure to notify DMAP of a change, particularly a change in Federal Tax Identification Number, may result in the imposition of a sanction from DMAP and may require Corrective Action to correct payment records, as well as any other action required to correctly identify payments to the appropriate TIN.

**b.** Contractor understands and agrees that DMAP through this Contract, Contractor is the "Entity" that DMAP is engaging the expertise, experience, judgment, representations and warranties, and certifications of the Contractor designated in this Contract. Contractor shall not transfer,

Subcontract, reassign or sell its contractual or ownership interests, such that Contractor is no longer available to provide DMAP with its expertise, experience, judgment and representations and certifications, without first obtaining DMAP's prior written approval 60 days before such transfer, subcontract, reassignment or sale occurs, except as otherwise provided in Exhibit B, Part II, Section 2 of this Contract governing Adjustments in Service Area or Enrollment, and Exhibit D, Section 16, Subcontracting.

**c.** As a condition precedent to obtaining DMAP's approval, not later than 60 days before the transfer, subcontract, reassignment or sale occurs, Contractor shall provide to DMAP:

**(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;

**(2)** Representation and warranty signed and dated by the proposed new Entity and by Contractor that warrants and represents that the policies, procedures and processes issued by the current Contractor will be those policies, procedures, or processes provided to DMAP 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 DMAP 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, DMAP shall be provided with the new policies, procedures and processes proposed by the proposed new Entity for review consistent with the requirements of this Contract;

**(3)** The financial responsibility and solvency information for the proposed new Entity for DMAP review consistent with the requirements of this Contract;

**(4)** Contractor's assignment/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 DMAP 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. DMAP reserves the right to require Contractor to provide such additional information and/or take such actions as may reasonably be required to assure full compliance with Contract terms as a condition precedent to DMAP's agreement to accept the assignment/assumption or other agreement; and

**(5)** DMAP will review the information to determine that the proposed new Entity is qualified to perform the Statement of Work and to assume rights and responsibilities of the Contractor under this Contract. DMAP's review will be based upon the requirements of this Contract. DMAP reserves the right to require such additional information and/or measures it deems appropriate as a condition precedent to DMAP's agreement to accept the assignment/assumption or other agreement.

**d.** Contractor shall disclose to DMAP within the notes of the Annual Audited Financial Reports any sale, exchange or lease of any property, any lending of money or other extension of credit and any furnishing for consideration of goods, services or facilities between the Contractor and any party of interest, excluding regular business operation administrative expenses, such as

compensation and bonuses made to personnel. Party of interest is defined as 1) any director, officer, partner, affiliate, or employee responsible for management or administration of the Contractor, 2) any person who is directly or indirectly the beneficial owner of more than 5% of the net worth of the Contractor, 3) any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by, and valuing more than 5% of the Contractor, or 4) in the case of a Contractor organized as a nonprofit corporation, an incorporator or member of such corporation under applicable State corporation law.

**7. Indemnification**

CONTRACTOR SHALL DEFEND, SAVE, HOLD HARMLESS AND INDEMNIFY THE STATE OF OREGON, AND ITS AGENCIES, SUBDIVISIONS, OFFICERS, EMPLOYEES, AND AGENTS FROM AND AGAINST ALL CLAIMS, SUITS, ACTIONS, LOSSES, DAMAGES, LIABILITIES, COSTS AND EXPENSES OF ANY NATURE WHATSOEVER RESULTING FROM, ARISING OUT OF, OR RELATING TO THE ACTIVITIES OF CONTRACTOR OR ITS OFFICERS, EMPLOYEES, SUBCONTRACTORS, OR AGENTS UNDER THIS CONTRACT; PROVIDED, THAT DMAP SHALL PROVIDE CONTRACTOR WITH PROMPT WRITTEN NOTICE OF ANY SUCH CLAIM, SUIT, ACTION OR PROCEEDING AND REASONABLE ASSISTANCE, AT CONTRACTOR'S EXPENSE, IN THE DEFENSE THEREOF.

CONTRACTOR SHALL HAVE CONTROL OF THE DEFENSE AND SETTLEMENT THEREOF, BUT NEITHER CONTRACTOR NOR ANY ATTORNEY ENGAGED BY CONTRACTOR, SHALL DEFEND THE CLAIM IN THE NAME OF THE STATE OF OREGON OR ANY AGENCY OF THE STATE OF OREGON, NOT PURPORT TO ACT AS LEGAL REPRESENTATIVE OF THE STATE OF OREGON OR ANY OF ITS AGENCIES, WITHOUT THE PRIOR WRITTEN CONSENT OF THE OREGON ATTORNEY GENERAL. THE STATE OF OREGON MAY, AT ITS ELECTION AND EXPENSE, ASSUME ITS OWN DEFENSE AND SETTLEMENT IN THE EVENT THAT THE STATE OF OREGON DETERMINES THAT CONTRACTOR IS PROHIBITED FROM DEFENDING THE STATE OF OREGON, IS NOT ADEQUATELY DEFENDING ITS INTERESTS, AN IMPORTANT GOVERNMENTAL PRINCIPLE IS AT ISSUE, OR IT IS IN THE BEST INTEREST OF THE STATE OF OREGON TO DO SO.

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

THE OBLIGATIONS OF THIS SECTION 7 ARE SUBJECT TO THE LIMITATIONS IN SECTION 11 OF THIS EXHIBIT.

## 8. Events of Default

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

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

**(2)** Contractor no longer holds a license or certificate that is required for Contractor to perform the Work and Contractor has not obtained such license or certificate within ten (10) Business Days after delivery of DMAP's notice or such longer period as DMAP may specify in such notice;

**(3)** Contractor commits any material breach or default of any covenant, warranty, obligation or certification under this Contract, fails to perform the Work in conformance with the specifications and warranties provided herein, or so fails to pursue the Work as to endanger Contractor's performance under this Contract in accordance with its terms, and such breach, default or failure is not cured within ten (10) Business Days after delivery of DMAP's notice or such longer period as DMAP may specify in such notice;

**(4)** Contractor knowingly has a director, officer, partner or person with beneficial ownership of more than 5% of Contractor's equity or has an employment, consulting or other Subcontractor agreement for the provision of items and services that are significant and material to Contractor's obligations under this Contract, concerning whom:

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

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

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

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

**(5)** If DMAP determines that health or welfare of DMAP Members is in jeopardy if this Contract continues; or

**(6)** If DMAP Determines:

**(a)** That amendment of this Contract is required due to change(s) in federal or State law or regulations, or due to changes in Covered Services or Capitation Payments under ORS 414.735;

**(b)** That failure to amend this Contract to execute those changes in the time and manner proposed in the amendment may place DMAP at risk of non-compliance with federal or State statute or regulations or changes required by the Legislative Assembly or the Legislative Emergency Board; or

**(c)** That Contractor failed to execute the amendment to the Contract within the time allowed.

**b. Default by DMAP**

DMAP shall be in default under this Contract if:

**(1)** DMAP fails to pay Contractor any amount pursuant to the terms of this Contract, and DMAP fails to cure such failure within fifteen (15) days after delivery of Contractor's notice or such longer period as Contractor may specify in such notice; or

**(2)** DMAP commits any other material breach or default of any covenant, warranty, or obligation under this Contract, fails to perform its commitments hereunder within the time specified or any extension thereof, and DMAP fails to cure such failure within ten (10) Business Days after delivery of Contractor's notice or such longer period as Contractor may specify in such notice.

**9. Remedies for Default**

**a.** DMAP's Remedies

In the event Contractor is in default under Exhibit D, Section 8, of this Contract, DMAP may, at its option, pursue any or all of the remedies available to it under this Contract and at law or in equity, including, but not limited to:

**(1)** Termination of this Contract under Exhibit D, Section 10, Subsection a. (1);

**(2)** Withholding payments under Exhibit C for Work that does not have a required DMAP approval or has not met the service levels set forth in this Contract;

**(3)** Sanctions under Exhibit B, Part VI, Section 2 of this Contract;

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

**(5)** Exercise of its right of setoff.

These remedies are cumulative to the extent the remedies are not inconsistent, and DMAP may pursue any remedy or remedies singly, collectively, successively or in any order whatsoever. If it is determined for any reason that Contractor was not in default under Exhibit D, Section 8 of this Contract, the rights and obligations of the parties shall be the same as if this Contract was terminated pursuant to Exhibit D, Section 10 Subsection a. (1).

**b.** Contractor's Remedies

In the event DMAP terminates this Contract for convenience under Exhibit D, Section 10, or in the event DMAP is in default under Exhibit D, Section 8 and whether or not Contractor elects to exercise its right to terminate this Contract under Exhibit D, Section 10, Contractor's sole monetary remedy shall be a Claim for any unpaid Capitation Payments as identified in Exhibit C less previous amounts paid and any claims which DMAP has against Contractor. If previous amounts paid to Contractor exceed the amount due to Contractor under this Exhibit D, Section 9, Contractor shall pay any excess to DMAP upon written demand.

## 10. Termination

**a.** This Contract may be terminated under any of the following conditions:

**(1)** This Contract may be terminated by mutual consent of both parties or by either party upon ninety (90) days written notice by certified mail. If Contractor initiates termination, DMAP has a right to full disclosure of Contractor's records pertinent to Contractor's decision to terminate. Contractor shall promptly provide such disclosure to DMAP upon demand;

**(2)** DMAP may terminate this Contract effective upon delivery of written notice to Contractor, or at such later date as may be established by DMAP, under any of the following conditions:

**(a)** If DMAP funding from federal, State or other sources is not obtained, or is withdrawn, reduced or limited, or if DMAP expenditures are greater than anticipated, such that funds are insufficient to allow for the purchase of services as required by this Contract; or

**(b)** If federal or State regulations or guidelines or CMS waiver terms are modified, changed or interpreted in such a way that DMAP determines that services are no longer allowable or appropriate for purchase under this Contract or are no longer eligible for the funding proposed for payments under this Contract.

**(3)** DMAP may by written notice of default or breach of Contract for circumstances described in Exhibit D, Section 9, terminate the whole or any part of this Contract.

**(4)** Before terminating this Contract under Paragraph (3) of this subsection, DMAP shall:

**(a)** Provide Contractor with a written notice of its intent to terminate, the reason for termination, and the opportunity to Provider appeal pursuant to OAR 410-120-1560. Where termination is based on failure to comply with Corrective Action under Exhibit B, Part II, Section 2 and Contractor has had an Administrative Review on issues substantially similar to the basis for the termination decision, such Administrative Review is deemed to satisfy the requirement for a pre-termination hearing;

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

**(c)** After a decision affirming termination, give DMAP Members notice of the termination and information on their options for receiving Medicaid services following the effective date of the termination; and

**(d)** After DMAP notifies Contractor that it intends to terminate its Contract under Paragraph (3) of this subsection, DMAP must give the affected DMAP Members written notice of DMAP's intent to terminate this Contract and allow affected DMAP Members to Disenroll immediately without cause.

**b.** In the event of termination of this Contract or at the end of the term of this Contract if Contractor does not execute a new Contract with DMAP, the following provisions shall apply to ensure continuity of the Work by Contractor. Contractor shall ensure:

**(1)** Continuation of services to DMAP Members for the period in which a Capitation Payment has been made, including Inpatient admissions up until discharge;

**(2)** Orderly and reasonable transfer of DMAP Member care in progress, whether or not those DMAP Members are hospitalized;

**(3)** Timely submission of information, reports and records, including Encounter Data, required to be provided to DMAP during the term of this Contract;

**(4)** Timely payment of Valid Claims for services to DMAP Members for dates of service included in the Contract Year; and

**(5)** If Contractor continues to provide services to a DMAP Member after the date of termination, DMAP is only authorized to pay for services subject to DMAP rules on a fee-for-service basis if the former DMAP Member is DMAP eligible and not covered under any other DMAP Contractor. If Contractor chooses to provide services to a former DMAP Member who is no longer DMAP eligible, DMAP shall have no responsibility to pay for such services.

**c.** Upon termination, DMAP shall conduct an accounting of Capitation Payments paid or payable and DMAP Members enrolled during the month in which termination is effective and shall be accomplished as follows:

**(1)** Mid-Month Termination: For a termination of this Contract that occurs during mid-month, the Capitation Payments for that month shall be apportioned on a daily basis. Contractor shall be entitled to Capitation Payments for the period of time prior to the date of termination and DMAP shall be entitled to a refund for the balance of the month.

**(2)** Responsibility for Capitated Payment/Claims: Contractor is responsible for any and all Claims from Subcontractors or other Providers, including Emergency Service Providers, for Capitated Services provided prior to the termination date.

**(3)** Notification of Outstanding DMAP Claims: Contractor shall promptly notify DMAP of any outstanding Claims for which DMAP may owe, or be liable for, or a fee-for-service payment(s), which are known to Contractor at the time of termination or when such new Claims incurred prior to termination are received. Contractor shall supply DMAP with all information necessary for reimbursement of such Claims.

**(4)** Responsibility to Complete Contractual Obligations: Contractor is responsible for completing submission and corrections to encounter data for services received by DMAP Members during the period of this Contract. Contractor is responsible for submitting financial and other reports required during the period of this Contract.

**(5)** Withholding: Pending Completion of Contractual Obligations: DMAP shall withhold 20% of the Contractor's last Capitation Payment until Contractor has complied with all contractual obligations. DMAP's determination of completion of Contractor's contractual obligations shall be no sooner than 6 months from the date of termination. Failure to complete said contractual obligations within a reasonable time period shall result in a forfeiture of the 20% withhold.

**d.** If this Contract expires as provided under Part I, Term and Approval, Subsection A., Contractor shall comply with the requirements applicable to Contractor that are set forth in Subsection b. and c of this section as if this Contract terminated.

**11. Limitation of Liabilities.**

**a.** Neither party shall be liable to the other for any incidental or consequential damages arising out of or related to this Contract. Neither party shall be liable for any damages of any sort arising solely from the termination of this Contract of any part hereof in accordance with its terms.

**b.** Contractor shall ensure that the DHS is not held liable for any of the following:

**(1)** Payment for Contractor's or any Subcontractor's debts or liabilities in the event of insolvency; or

**(2)** Capitated Services authorized or required to be provided under this Contract.

**12. Insurance**

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

**13. Access to Records and Facilities**

**a. Access**

Contractor shall provide, and shall require its Subcontractors to provide, the timely and unrestricted right of access to its facilities and to its books, documents, papers, plans, writings, financial and clinical records and all accompanying billing records that are directly pertinent to this Contract in order to make audits, examinations, excerpts, transcripts and copies of such documents to:

**(1)** DMAP;

**(2)** The Oregon Department of Human Services;

**(3)** The U. S. Centers for Medicare and Medicaid Services;

**(4)** The Comptroller General of the United States;

**(5)** The Oregon Secretary of State;

**(6)** The Oregon Department of Justice Medicaid Fraud Control Unit; and

**(7)** All their duly authorized representatives.

Records shall be made available for the purposes of research, data collections, evaluations, monitoring, and auditing activities, examination, excerpts and transcriptions. Contractor shall, upon request and without charge, provide a suitable work area and copying capabilities to facilitate such a review or audit. This right also includes timely and reasonable access to Contractor's personnel and Subcontractors for the purpose of interview and discussion related to such documents. The rights of access in this subsection are not limited to the required retention period, but shall last as long as the records are retained.

**b. Confidentiality**

Except as required by Subsection a., of this section, Contractor and its agents, employees and Subcontractors shall maintain all DMAP Member information and records, whether hard copy or computerized, as confidential, consistent with OAR 410-141-0180, Oregon Health Plan Prepaid Health Plan Record keeping, and Exhibit B, Part V, Section 1 of this Contract.

**(1)** For the protection of DMAP Members and consistent with the requirements of 42 CFR Part 431, Subpart F and ORS 411.320, Contractor shall not disclose or use the contents of any records, files, papers or communications for purposes other than those directly connected with the administration of this Contract, except with the written consent or authorization of the DMAP Member, his or her attorney, Representative, or except as permitted by ORS 179.505 or by 2007 Senate Bill 163 and the DHS rules thereunder.

**(2)** If Contractor or its Subcontractor is a public body within the meaning of the Oregon Public Records Law, the Contractor or Subcontractor shall ensure that the confidentiality of DMAP Members is maintained in accordance with ORS 192.502(2) (personal privacy exemption), ORS 192.502(8) (confidential under federal law), and ORS 192.502(9) (confidential under State law) or other relevant exemptions.

**(3)** To the extent that information about DMAP Members includes confidential protected health information or records about alcohol and drug abuse treatment, mental health treatment, HIV/AIDS, and/or genetics, Contractor, its agents, employees and Subcontractors shall comply with the specific confidentiality requirements applicable to such information or records under federal and State law.

**(4)** Contractor, its agents, employees and Subcontractors shall ensure that confidential records are secure from unauthorized disclosure. Electronic storage and transmission of confidential DMAP Member information and records shall assure accuracy, backup for retention, and safeguards against tampering, backdating, or alteration.

**c.** Contractor understands and agrees that information prepared, owned, used or retained by the DHS is subject to the Public Records Law, ORS 192.410 et. seq.

## 14. Force Majeure

**a.** Neither Contractor nor DMAP shall be held responsible for delay or default caused by fire, riot, war, and/or acts of God when they affect Contractor's ability to perform the Work, which is beyond either Contractor's or DMAP's reasonable control. Contractor or DMAP shall, however, make all reasonable efforts to remove or eliminate such a cause of delay or default and shall, upon the cessation of the cause, diligently pursue performance of its obligations under this Contract.

**b.** If the rendering of services or benefits under this Contract is delayed or made impractical due to a major disaster, epidemic, or labor dispute involving Contractor, care may be deferred until after resolution of the labor dispute except in the following situations:

**(1)** Care is needed for Emergency Services;

**(2)** Care is needed for Urgent Care Services; or

**(3)** Care is needed where there is a potential for a serious adverse medical consequence if treatment or diagnosis is delayed more than sixty (60) days.

**c.** If a major disaster, epidemic, or labor dispute disrupts normal execution of Contractor duties under this Contract, Contractor shall notify DMAP Members in writing of the situation and direct DMAP Members to bring serious health care needs to Contractor's attention.

## 15. Successors in Interest

**a.** Contractor shall not assign or transfer any of its interest in this Contract without the prior written consent of DMAP. Subject to the immediately preceding sentence, the provisions of this Contract shall be binding upon and shall inure to the benefit of the parties hereto, and their respective successors and permitted assigns, if any. In addition to any other assignment or transfer of interest, for purposes of this Contract, all of the following fundamental changes shall be considered an assignment of an interest in this Contract subject to DMAP prior written consent.

**(1)** A 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

**(2)** 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.

**b.** Contractor shall notify DMAP at least forty-five (45) calendar days prior to any assignment or transfer of an interest in this Contract and shall reimburse DHS for all legal fees reasonably incurred by DHS in reviewing the proposed assignment or transfer and in negotiating and drafting appropriate documents.

## 16. Subcontracting

Contractor shall ensure that all subcontracts meet the requirement described below and shall incorporate portions of this Contract, as applicable, based on the scope of Work to be subcontracted.

**a.** Contractor is responsible for the quality of care and services and the timely and effective performance of Work provided under the terms and requirements of this Contract. Subject to the provisions of this section, Contractor may subcontract any or all of the Work to be performed under this Contract. No Subcontract shall terminate or limit Contractor's legal responsibility to the DHS 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.

**b.** Before subcontracting of any Work, Contractor shall evaluate the prospective Subcontractor's ability to perform the Work under a subcontract.

**c.** Contractor shall have a written agreement (subcontract) that specifies the subcontracted Work and reporting responsibilities of the Subcontractor. Contractor shall notify the DHS in writing of Work to be subcontracted.

**d.** The following requirements of this Contract may not be subcontracted:

**(1)** Oversight and monitoring of quality improvement activities;

**(2)** Adjudication of final Appeals in a DMAP Member Complaint and Appeal process; and

**(3)** Financial responsibility, risk and solvency requirements of Exhibit B, Part IV, Section 1, of this Contract.

**e.** Contractor's agreement with the Subcontractor shall 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.

**f.** 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. Upon identification of deficiencies or areas for improvement, the Contractor shall and shall cause Subcontractor to take Corrective Action.

**g.** In addition to any other provisions that DMAP may require, Contractor shall include a provision in all subcontracts that to the extent any provision in this Contract applies to Contractor with respect to the Work Contractor is providing to DMAP under a subcontract, that provision shall be incorporated by reference into the Subcontract and shall apply equally to Subcontractor.

**h.** Contractor shall ensure that all subcontracts meet the requirements described below and shall incorporate portions of this Contract, as applicable, based on the scope of Work to be subcontracted:

**(1)** Be in writing and incorporate each applicable requirement of this Contract, including the following: Exhibit B, Part V, Section 1, Record keeping; Exhibit D, Section 18 Amendments, Exhibit D, Section 10 Terminations, Exhibit D, Section 7, Indemnification;

Exhibit D, Section 25, Tort Claims; Exhibit F, Insurance Requirements; Exhibit D, Section 2, Compliance with Applicable Laws and Rules; Exhibit E, Required Federal Provisions; and every other provision in this Contract that sets requirements for any of the activities being subcontracted.

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);

**(2)** Clearly identify the Work to be performed by the Subcontractor and what of that Work, if any, the Subcontractor may further subcontract;

**(3)** Contain a provision requiring Subcontractor to comply with the requirements of 42 CFR 438.6 that are applicable to the Work required under the subcontract;

**(4)** Contain a provision that the Subcontractor shall not bill, charge, seek compensation, remuneration or reimbursement from, or have recourse against the DHS or any DMAP Member for Covered Services provided during the period for which Capitation Payments were made by the DHS through DMAP to Contractor with respect to said DMAP Member, even if Contractor becomes insolvent. Subcontractors and referral Providers may not bill DMAP Members any amount greater than would be owed by the DMAP Member if the Contractor provided the services directly (i.e., no balance billing by Providers);

**(5)** Contain a provision that the Subcontractor shall continue to provide Covered Services during periods of Contractor insolvency or cessation of operations through the period for which Capitation Payments were made to Contractor;

**(6)** Contain a provision requiring the Subcontractor to comply with OAR 410-141-0420, Billing and Payment under the OHP, when submitting Fee-for-Service Claims for OHP services provided to DMAP Members that are not Covered Services under this Contract;

**(7)** In cases where the Subcontractor has assumed any risk covered under this Contract, contain a provision that the Subcontractor must protect itself against loss by either self-insuring or providing proof of Reinsurance; and by maintaining a Restricted Reserve Fund as described in Exhibit G, Solvency Plan and Financial Reporting; and by providing Physician Incentive Plan stop-loss protection as required by Exhibit M;

**(8)** Contain a provision that health care Providers shall advise a DMAP Member who is the patient of the Provider about the health status of the DMAP Member, or any service, treatment or test that is Medically Appropriate but not authorized under the Plus or Standard Benefit Package of Covered Services, Exhibit B, Part I, Section 2, of this Contract or is subject to co-payments, if the Provider is acting within the lawful scope of practice, and an ordinarily careful practitioner in the same or similar community would do so under the same or similar circumstances;

**(9)** Contain a provision requiring the Subcontractor to provide notices of denials, reductions, discontinuation or termination of services or service coverage consistent with the requirements of OAR 410-141-0263, Notice of Action by a PHP; including but not limited to:

**(a)** the DMAP Member's right to a state fair hearing, how to obtain a hearing, and representation rules at a hearing;

**(b)** the DMAP Member's right to file grievances and Appeals and their requirements and timeframes for filing;

**(c)** the availability of assistance in filing;

**(d)** the toll-free numbers to file oral grievances and Appeals;

**(e)** the DMAP Member's right to request continuation of benefits during an appeal or state fair hearing filing and, if the Contractor's action is upheld in a hearing, the DMAP Member may be liable for the cost of any continued benefits; and

**(f)** any state-determined provider appeal rights to challenge the failure of the Contractor to cover a service.

**(10)** If Contractor chooses to delegate the Complaint and Appeal process, except the adjudication of final Appeals, Contractor shall require the Subcontractor to have written policies and procedures for accepting, processing and responding to all Complaints and Appeals from family members, and DMAP Members consistent with Exhibit B, Part III, Section 3;

**(11)** Contain a provision that data used for analysis of delivery system capacity, consumer satisfaction, financial solvency, encounter, utilization and quality improvement, and other reporting requirements under this Contract must be provided to Contractor within time frames sufficient to allow Contractor to meet its reporting requirements under this Contract;

**(12)** Contain a provision that requires the Subcontractor to participate in internal or external quality improvement activities of Contract, or those of the DHS, if requested to do so;

**(13)** Contain a provision that requires the Subcontractor to provide access to records and facilities as described in OAR 410-141-0180, Oregon Health Plan Prepaid Health Plan Record Keeping; Exhibit B, Part V, Section 1, Record Keeping;

**(14)** Contain a provision requiring the Subcontractor to maintain the confidentiality of DMAP Member records and information as described in Exhibit D, Section 13, Access to Records and Facilities;

**(15)** Contain a provision that requires the Subcontractor to cooperate with all processes and procedures of child, elder, nursing home, developmentally disabled or mentally ill abuse reporting, investigations, and protective services;

**(16)** Contain a provision that requires Subcontractor to comply with Contractor's Fraud and Abuse policies under Exhibit E, Section 2, and Exhibit J, Fraud and Abuse Reporting Requirements, and to cooperate with all processes and procedures of fraud and abuse investigations, reporting requirements, and related activities by Contractor, the DHS, or the Department of Justice Medicaid Fraud Control Unit.

**(17)** Contain a requirement that the Subcontractor shall certify that all Claims submissions and/or information received from the Subcontractor are true, accurate, and complete; and that payment of the Claims by the Contractor will be from Federal and State funds, and therefore any falsification, or concealment of material fact by the Subcontractor when submitting Claims may be prosecuted under Federal and State laws.

**i.** Contractor shall have written policies and procedures for selection and retention of Participating Providers.

## 17. No Third Party Beneficiaries

DHS and Contractor are the only parties to this Contract and are the only parties entitled to enforce its terms. Nothing in this Contract gives, is intended to give, or shall be construed to give or provide any benefit or right, whether directly, indirectly or otherwise, to third persons unless such third persons are individually identified by name herein and expressly described as intended beneficiaries of the terms of this Contract.

## 18. Amendments

**a.** Except as specifically permitted by this Contract, the terms of this Contract shall not be waived, altered, modified, supplemented or amended in any manner whatsoever without a duly executed written amendment to this Contract. Any amendments to this Contract shall be effective only when produced in writing and signed by all parties, and approved for legal sufficiency by the Department of Justice, when required.

**b.** DMAP shall provide Contractor with an amendment if DMAP is required to amend this Contract due to changes in federal or State statute or regulations, or due to changes in Covered Services and Capitation Payments under ORS 414.735, and if failure to amend this Contract to execute those changes in the time and manner proposed in the amendment may place DMAP at risk of non-compliance with federal or State statute or regulations or the requirements of the Legislature or Legislative Emergency Board. DMAP may provide Contractor with an amendment if the DMAP actuary recalculates Standard population Capitation Payment rates under Exhibit C, Section 3. DMAP will send to Contractor the necessary Contract amendment(s) no later than fifteen (15) days before the proposed effective date of the amendment; and thirty (30) days for review of a rate sheet before the proposed effective date of the amendment of the Capitation Payment rates.

Any changes in the Capitation Payment rates under ORS 414.735 shall take effect on the date approved by the Legislative Assembly or the Legislative Emergency Board. Any changes required by federal or State law or regulation shall take effect not later than the effective date of the federal or State law or regulation.

**(1)** If Contractor intends to accept the amendment(s), Contractor shall execute the amendment in sufficient time to comply with the proposed effective date.

**(2)** If Contractor does not accept the amendment(s) in sufficient time to comply with the proposed effective date, and if DMAP determines that the failure to implement the amendment to this Contract would place DMAP at risk of non-compliance with federal or State law or rules, DMAP shall provide written notice of its intent to terminate this Contract pursuant to Exhibit D, Section 10 of this Contract and/or pursue other remedies available to DMAP under this Contract.

**19. Severability**

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

**20. Waiver**

The failure of either party to enforce any provision of this Contract shall not constitute a waiver of that or any other provision.

**21. Notices**

**a.** Except as otherwise expressly provided in this Contract, any communications between the parties hereto or notices to be given hereunder shall be given in writing by personal delivery, facsimile or mailing the same, postage prepaid, to Contractor or DMAP at the addresses or facsimile numbers set forth in this section, or to such other addresses or facsimile numbers as either party may hereinafter indicate pursuant to this section. Any communication or notice so addressed and mailed shall be deemed to be given five (5) days after mailing. Any communication or notice delivered by facsimile shall be deemed to be given when the transmitting machine generates receipt of the transmission. To be effective against DMAP, such facsimile transmission must be confirmed by telephone notice to DMAP's Contract Administrator. Any communication or notice by personal delivery shall be deemed to be given when actually delivered.

**(1)** If to Contractor:

To the person designated as point of contact in the Part III, Section C of this Contract captioned Status of Contractor at the address of the Contractor.

**(2)** If to a DMAP Member:

To the latest address provided for the DMAP Member on an address list, Enrollment or change of address form actually delivered to Contractor.

**(3)** If to DMAP:

DMAP Contract Administrator
Dept. of Human Services
500 Summer St. N.E.
Salem, Oregon 97301

**22. Construction**

This Contract is the product of extensive negotiations between DHS and Contractor. The provisions of this Contract are to be interpreted and their legal effects determined as a whole. A court interpreting this Contract shall give a reasonable, lawful and effective meaning to this Contract to the extent possible.

## 23. Headings/Captions

The headings used in this Contract are for reference and convenience only, and in no way define, limit, or describe the scope or intent of any provisions or sections of this Contract.

## 24. Merger

This Contract constitutes the entire Contract between the parties. No waiver, consent, modification or change of terms of this Contract shall bind either party unless in writing and signed by both parties and all necessary State of Oregon approvals have been obtained. Such waiver, consent, modification, or change, if made, shall be effective only in the specific instance and for the specific purpose given. There are no understandings, agreements, or representations, oral or written, not specified herein regarding this Contract. Contractor, by the signature below of its authorized representative, hereby acknowledges that he or she has read this Contract, understands it, and agrees to be bound by its terms and conditions.

## 25. Tort Claims

Contractor and its Subcontractors, employees, and agents are performing the Work under this Contract as independent contractors and not as officers, employees, or agents of the State as those terms are used in ORS 30.265.

## 26. Counterparts

This Contract may be executed in several counterparts, all of which when taken together shall constitute one agreement binding on all parties, notwithstanding that all parties are not signatories to the same counterpart. Each copy of this Contract so executed shall constitute an original.

# EXHIBIT E - Required Federal Terms and Conditions

Contractor shall comply and, as indicated, cause all Subcontractors to comply with the following federal requirements to the extent that they are applicable to this Contract, to Contractor, or to the Work, or to any combination of the foregoing. For purposes of this Contract, all references to federal and State laws are references to federal and State laws as they may be amended from time to time.

## 1. Miscellaneous Federal Provisions

Contractor shall comply and cause all Subcontractors to comply with all federal laws, regulations, executive orders applicable to this Contract or to the delivery of Work. Without limiting the generality of the foregoing, Contractor expressly agrees to comply and cause all Subcontractors to comply with the following laws, regulations and executive orders to the extent they are applicable to this Contract: (a) Title VI and VII of the Civil Rights Act of 1964, (b) 45 CFR Part 84 which implements , Title V, Sections 503 and 504 of the Rehabilitation Act of 1973, (c) the Americans with Disabilities Act of 1990, (d) Executive Order 11246, (e) the Health Insurance Portability and Accountability Act of 1996, (f) the Age Discrimination in Employment Act of 1967, as amended, and the Age Discrimination Act of 1975, (g) the Vietnam Era Veterans' Readjustment Assistance Act of 1974, all regulations and administrative rules established pursuant to the foregoing laws, (i) all other applicable requirements of federal civil rights and rehabilitation statutes, rules and regulations, (j) all federal law governing operation of Community Mental Health Programs, including without limitation, all federal laws requiring reporting of Client abuse. These laws, regulations and executive orders are incorporated by reference herein to the extent that they are applicable to this Contract and required by law to be so incorporated. No federal funds may be used to provide Work in violation of 42 USC 14402.

## 2. Prevention and Detection of Fraud and Abuse

Contractor shall have in place internal controls, policies or procedures capable of preventing and detecting Fraud and Abuse activities as they relate to the OHP as outlined in Exhibit J, Fraud and Abuse policies and procedures shall be reviewed annually. Contactor shall submit to DHS for review and approval written Fraud and Abuse policies and procedures, due within 30 days of the effective date of this Contract.

## 3. Equal Employment Opportunity

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

## 4. Clean Air, Clean Water, EPA Regulations

If this Contract, including amendments, exceeds $100,000 then Contractor shall comply and cause all Subcontractors to comply with all applicable standards, orders, or requirements issued under Section 306 of the Clean Air Act (42 U.S.C. 7606), the Federal Water Pollution Control Act as amended (commonly known as the Clean Water Act) (33 U.S.C. 1251 to 1387), specifically including, but not limited to Section 508 (33 U.S.C. 1368). Executive Order 11738, and Environmental Protection Agency regulations (40 CFR Part 32), which prohibit the use under non-exempt federal contracts, grants or loans of facilities included on the EPA List of Violating

Facilities. Violations shall be reported to DHS, DHHS and the appropriate Regional Office of the Environmental Protection Agency. Contractor shall include and cause all Subcontractors to include in all contracts with Subcontractors receiving more than $100,000, language requiring the Subcontractor to comply with the federal laws identified in this section.

**5. Energy Efficiency**

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

**6. Truth in Lobbying**

The Contractor certifies, to the best of the Contractor's knowledge and belief that:

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

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

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

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

**7. HIPAA Compliance**

If the Work funded in whole or in part with financial assistance provided under this Contract are covered by the Health Insurance Portability and Accountability Act or the federal regulations implementing the Act (collectively referred to as HIPAA), Contractor agrees to deliver the Work in compliance with HIPAA. Without limiting the generality of the foregoing, Work funded in whole or in part with financial assistance provided under this Contract are covered by HIPAA. Contractor shall comply and cause all Subcontractors to comply with the following:

**a.** Privacy and Security Of Individually Identifiable Health Information Individually Identifiable Health Information about specific individuals is confidential. Individually Identifiable Health Information relating to specific individuals may be exchanged between Contractor and DHS for purposes directly related to the provision of services to Clients which are funded in whole or in part under this Contract. However, Contractor shall not use or disclose any Individually Identifiable Health Information about specific individuals in a manner that would violate DHS Privacy Rules, OAR 410-014-0000 et. seq., or DHS Notice of Privacy Practices, if done by DHS. A copy of the most recent DHS Notice of Privacy Practices is posted on the DHS web site at http://www.dhs.state.or.us/policy/admin/infosecuritylist.htm, or may be obtained from DHS.

**b.** Data Transactions Systems. If Contractor intends to exchange electronic data transactions with DHS in connection with Claims or encounter data, eligibility or enrollment information, authorizations or other electronic transaction, Contractor shall execute an EDI Trading Partner Agreement with DHS and shall comply with the DHS EDI Rules.

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

## 8. Resource Conservation and Recovery

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

## 9. Audits

Contractor shall comply and, if applicable, cause a Subcontractor to comply, with the applicable audit requirements and responsibilities set forth in the Office of Management and Budget Circular A-133 entitled "Audits of States, Local Governments and Non-Profit Organizations."

## 10. Debarment and Suspension

Contractor shall not permit any person or entity to be a Subcontractor if the person or entity is listed on the non-procurement portion of the General Service Administration's "List of Parties Excluded from Federal Procurement or Nonprocurement Programs" in accordance with Executive Orders No. 12,549 and No. 12,689, "Debarment and Suspension". (See 45 CFR Part 76). This list contains the names of parties debarred, suspended, or otherwise excluded by agencies, and contractors declared ineligible under statutory authority other than Executive Order No. 12549. Subcontractors with awards that exceed the simplified acquisition threshold shall provide the required certification regarding their exclusion status and that of their principals prior to award.

## 11. Drug-Free Workplace

Contractor shall comply and cause all Subcontractors to comply with the following provisions to maintain a drug-free workplace:

**a.** Contractor certifies that it will provide a drug-free workplace by publishing a statement notifying its employees that the unlawful manufacture, distribution, dispensation, possession or use of a controlled substance, except as may be present in lawfully prescribed or over-the-counter medications, is prohibited in Contractor's workplace or while providing services to DHS clients. Contractor's notice shall specify the actions that will be taken by Contractor against its employees for violation of such prohibitions;

**b.** Establish a drug-free awareness program to inform its employees about: The dangers of drug abuse in the workplace, Contractor's policy of maintaining a drug-free workplace, any available drug counseling, rehabilitation, and employee assistance programs, and the penalties that may be imposed upon employees for drug abuse violations;

**c.** Provide each employee to be engaged in the performance of services under this contract a copy of the statement mentioned in Paragraph 11 a above;

**d.** Notify each employee in the statement required by Paragraph 11 a that, as a condition of employment to provide services under this contract, the employee will: abide by the terms of the statement, and notify the employer of any criminal drug statute conviction for a violation occurring in the workplace no later than five (5) days after such conviction;

**e.** Notify DHS within ten (10) days after receiving notice under Subparagraph 11d from an employee or otherwise receiving actual notice of such conviction;

**f.** Impose a sanction on, or require the satisfactory participation in a drug abuse assistance or rehabilitation program by any employee who is so convicted as required by Section 5154 of the Drug-Free Workplace Act of 1988;

**g.** Make a good-faith effort to continue a drug-free workplace through implementation of Subparagraphs 11 a through 11 f;

**h.** Require any Subcontractor to comply with Subparagraphs 11 a through 11 g;

**i.** Neither Contractor, or any of Contractor's employees, officers, agents or Subcontractors may provide any service required under this contract while under the influence of drugs. For purposes of this provision, "under the influence" means: observed abnormal behavior or impairments in mental or physical performance leading a reasonable person to believe the Contractor or Contractor's employee, officer, agent or Subcontractor has used a controlled substance, prescription or non-prescription medication that impairs the Contractor or Contractor's employee, officer, agent or Subcontractor's performance of essential job function or creates a direct threat to DHS clients or others. Examples of abnormal behavior include, but are not limited to: hallucinations, paranoia or violent outbursts. Examples of impairments in physical or mental performance include, but are not limited to: slurred speech, difficulty walking or performing job activities;

**j.** Violation of any provision of this subsection may result in termination of this Contract.

## 12. Pro-Children Act

Contractor shall comply and cause all sub-contractors to comply with the Pro-Children Act of 1994 (codified at 20 USC Section 6081 et. seq.).

## 13. Medicaid Services

Contractor shall comply with all applicable federal and State laws and regulations pertaining to the provision of Medicaid Services under the Medicaid Act, Title XIX, 42 USC Section 1396 et. Seq., including without limitation:

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

**b.** Comply with all disclosure requirements of 42 CFR 1002.3(a) and 42 CFR 455 Subpart (B).

**c.** Maintain written notices and procedures respecting advance directives in compliance with 42 USC Section 1396(a)(57) and (w), 42 CFR 431.107(b)(4), and 42 CFR 489 Subpart I.

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

**e.** Entities receiving $5 million or more annually (under this contract and any other Medicaid contract) for furnishing Medicaid health care items or services shall, as a condition of receiving such payments, adopt written fraud, waste and abuse policies and procedures and inform employees, contractors and agents about the policies and procedures in compliance with Section 6032 of the Deficit Reduction Act of 2005, 42 USC § 1396a(a)(68).

## 14. Clinical Laboratory Improvements

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

## 15. Advance Directives

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

**a.** Their rights under Oregon law; and

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

## 16. Office of Minority, Women and Emerging Small Businesses

If Contractor lets any subcontracts, Contractor shall take affirmative steps to: include qualified small and minority and women's businesses on solicitation lists, assure that small and minority and women's businesses are solicited whenever they are potential sources, divide total requirements into smaller tasks or quantities when economically feasible so as to permit maximum small and minority and women's business participation, establish delivery schedules when requirements permit which will encourage participation by small and minority and women's businesses, and use the Services and assistance of the Small Business Administration, the Office of Minority Business Enterprise of the Department of Commerce and the Community Services Administration as required.

## 17. Practitioner Incentive Plans (PIP)

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

## 18. Risk HMO

If Contractor is a Risk HMO and is sanctioned by CMS under 42 CFR 434.67, payments provided for under this Contract will be denied for OHP Members who enroll after the imposition of the sanction, as set forth under 42 CFR 434.42.

## 19. Conflict of Interest Safeguards

**a.** Contractor and their Subcontractor shall have in effect safeguards, including but not limited to policies and procedures against conflict of interest with any DHS employees or other agents of the State who have responsibilities relating to this Contract.

**b.** These safeguards must be at least as effective as the safeguards specified in Section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423) and must include safeguards to avoid conflicts that could be prohibited under 18 U.S.C. 207 or 208 if the DHS employee or agent was an officer or employee of the United States Government.

**c.** For purposes of implementing policies and procedures required in this section, Contractor shall apply the definitions in the State Public Ethics Laws as if they applied to Contractor for "actual conflict of interest," ORS 244.020(1), "potential conflict of interest," ORS 244.020(14), and "member of household," ORS 244.020(12).

**d.** Contractor safeguards must provide for financial and administrative independence for any individual conducting enrollment activities for purposes of the Division of Medical Assistance Programs (DMAP).

## 20. Non-Discrimination

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

## 21. OASIS

To the extent applicable, Contractor shall comply with, and shall require Subcontractors to comply with, the OASIS reporting requirements and patient notice requirements for skilled services provided by Home Health Agencies, pursuant to CMS requirements published in 64 FR3764, 64 FR 3748, 64 FR 23846, and 64 FR 32984, and such subsequent regulations as CMS may issue in relation to the OASIS program.

## 22. Patient Rights Condition of Participation

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

## 23. Federal Grant Requirements

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

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

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

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

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

**e.** Part 95 (Medicaid and SCHIP federal grant administration requirements); and

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

## 24. Provider's Opinion

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

Contractor shall not prohibit or otherwise restrict a Health Care Professional from advising a DMAP Member who is a patient of that professional about the health status of the DMAP Member or treatment for the DMAP Member's condition or disease, regardless of whether benefits for such care or treatment are provided under the Plus or Standard Benefit Package of Covered Services or if a co-payment may be required, if the professional is acting within the lawful scope of practice.

# EXHIBIT F – Insurance Requirements

During the term of this Contract, Contractor shall maintain in force at its own expense, each insurance noted below:

**1. Workers' Compensation Coverage**

With regard to workers' compensation insurance, all employers, including Contractor, that employ subject workers, as defined in ORS 656.027, shall provide workers' compensation insurance coverage for those workers, and must comply with ORS 656.017, unless they meet the requirements for an exemption under ORS 656.126(2). Contractor shall require and ensure that each of its Subcontractors complies with these requirements.

**2. Professional Liability Insurance**

Contractor shall maintain, and shall require that all persons and entities performing services under this Contract (except Oregon Licensed Direct Entry Midwives, of whom professional liability insurance is not required) obtain and keep in effect during the term of this Contract, professional liability insurance which provides coverage of direct and vicarious liability relating to any damages caused by an error, omission or any negligent acts related to the professional services provided under this Contract. Contractor shall maintain and shall require coverage of not less than the amount of $1,000,000 per person per incident and $1,000,000 in the aggregate;

**3. General Liability Insurance**

Contractor shall obtain and maintain General Liability insurance with a combined single limit, or the equivalent, of not less than $1,000,000, each occurrence for Bodily Injury and Property Damage. The policy shall be endorsed to also include contractual liability coverage for the Indemnity provided under this Contract. The policy shall provide that the State of Oregon, Department of Human Services, Division of Medical Assistance Programs, and its officers and employees are Additional Insureds but only with respect to Contractor's services to be provided under this Contract.

**4.** Catastrophic coverage through stop-loss or re-insurance shall be maintained pursuant to the requirements of the Statement of Work, Financial Solvency.

**5.** Physician Incentive Plan (PIP) stop-loss coverage shall be maintained pursuant to the requirements of the Statement of Work, Financial Solvency.

**6.** Proof of insurance shall be provided to DMAP upon request. As evidence of the insurance coverages required by this Contract, Contractor shall maintain acceptable insurance certificates. The certificate shall specify all of the parties who are Additional Insureds. Insuring companies shall be authorized to conduct business in the State of Oregon.

**7.** There shall be no cancellation, Material Change, reduction of limits or intent not to renew the insurance coverage(s) without thirty (30) days prior written notice from Contractor or its insurers to DMAP.

# EXHIBIT G – Solvency Plan and Financial Reporting

## 1. Background/Authority:

Contractor shall demonstrate to DMAP through proof of financial responsibility that it is able to perform the Work required under this Contract efficiently, effectively and economically and is able to comply with the requirements of this Contract. As part of the proof of financial responsibility, Contractor shall provide assurance satisfactory to DMAP that Contractor's provision(s) against the risk of insolvency are adequate to ensure the ability to comply with the requirements of this Contract. Contractor shall submit to DMAP all Reports attached to this Exhibit G as instructed in this Exhibit G.

## 2. Audited Financial Statements:

Contractor shall submit Audited Financial Statements to DMAP no later than June 30th following the last day of each calendar year that this Contract is in effect, except as otherwise specified herein. Audited Financial Statements shall be prepared by an independent accounting firm and shall include, but are not limited to, the following information:

**a.** A statement of opinion by the independent accounting firm about the financial statements based on the results of their audit;

**b.** A statement of opinion by an independent actuarial firm about the assumptions and methods used in determining loss reserve, actuarial liabilities and related items;

Contractors regulated by DCBS may submit the same forms submitted to DCBS, except as otherwise specified herein.

**c.** Balance Sheet(s). The information specified in Report G.5 shall be included in the Audited Yearly Balance Sheet of Corporate Activity or the accompanying notes or schedules to Financial Statements. Amounts reported on Report G.5 shall equal the amounts previously reported to DMAP on Reports G.7 for the 1st, 2nd, 3rd, and 4th quarters of the calendar year. Contractor shall amend prior Quarterly Financial Reports for audit adjustments and submit to DMAP no later then June 30th, following the last day of each calendar year that this Contract is in effect. Contractors regulated by DCBS shall submit the same forms submitted to DCBS and are not required to submit the information specified in Report G.5.

**d.** Statement of Revenue, Expenses and Changes in Fund Balance. The information specified in Report G.6 shall be included in the Audited Yearly Statement of Revenue, Expenses and Changes in Fund Balance or the accompanying Notes to Financial Statements. Amounts reported on Report G.6 shall equal the amounts previously reported to DMAP on Reports G.8 for the 1st, 2nd, 3rd, and 4th quarters of the calendar year. Contractor shall amend prior Quarterly Financial Reports G.8 for audit adjustments and submit to DMAP no later then June 30th, following the last day of each calendar year that this Contract is in effect. Contractors regulated by DCBS shall submit the Statement of Revenue, Expenses and Changes in Fund Balance submitted to DCBS. Contractors regulated by DCBS shall submit audited financial results in the format

required by DCBS and shall prepare amended prior Quarterly Financial Reports G.8 for audit adjustments no later then June 30th, following the last day of each calendar year that this Contract is in effect.

**e.** Statement of Cash Flow. The information specified in Report G.9 shall be included in the Audited Cash Flow Analysis for Corporate Activity or the accompanying Notes to Financial Statements. Contractor shall allocate cash flow using the Indirect Method of Accounting, as described by GAAP. Contractor regulated by DCBS shall submit the Cash Flow analysis submitted to DCBS, as described by NAIC.

**f.** Notes to Financial Statements; and

**g.** Any supplemental information deemed necessary by the independent accounting firm, actuary or DMAP.

**h.** Audited Financial Statements and the accompanying Notes to Financial Statements shall include information specified in Reports G.5, G.6, and G.9, attached to this Exhibit G. Contractor shall use Generally Accepted Accounting Principles (GAAP) to define the information requested. Contractors regulated by DCBS shall use National Association of Insurance Commission Annual Statement Instructions and Accounting Practices and Procedures.

**3. Quarterly Financial Reports:**

Contractor shall report results of financial operations to DMAP quarterly unless annotated as an annual requirement only. The reports identified below are included in this Exhibit G, and are incorporated herein by this reference and shall be referred to collectively as the Quarterly Financial Reports. Definitions and instructions for completing each report identified below have been included in this Exhibit G.

**a.** Quarterly Financial Reports include, but are not limited to, the following.

**(1)** General Information and Certification (Form G.1)

**(2)** Report G.1: Restricted Reserves; attach verification of account balances

**(3)** Report G.2: DMAP Members Approaching or Surpassing Stop-Loss Deductible

**(4)** Report G.3: (Rescinded)

**(5)** Report G.4: OHP Access to Services Statistics

**(6)** Report G.7: Quarterly Balance Sheet of Corporate Activity

**(7)** Report G.8: Quarterly Statement of Revenue, Expenses and Net Worth

**(8)** Report G.9: Cash Flow Analysis for Corporate Activity

**(9)** Report G.10: Corporate Relationship of Contractors (Parts I, II and IV) (Part III is an annual requirement only, due August 31st of the following year)

**(10)** Report G.11: Incurred but not reported

**b.** DMAP will supply Contractor with an Excel spreadsheet containing the Quarterly Financial Reports. Contractor shall submit the Quarterly Financial Reports to DMAP in an electronic format approved by DMAP. Contractor has the option of submitting the Excel spreadsheet to DMAP either electronically or by mailing a diskette containing the Quarterly Financial Reports to DMAP.

**c.** Contractor shall submit Quarterly Financial Reports for the 1st, 2nd, and 3rd quarters to DMAP 45 days after the end of each calendar quarter. Contractor shall submit the Quarterly Financial Reports for the 4th quarter three calendar months after the end of the calendar quarter, as follows:

| End of Quarter | Due Date of Report |
|---|---|
| March 31st | May 15th |
| June 30th | August 15th |
| September 30th | November 15th |
| December 31st | March 31st |

**d.** Contractor shall use Generally Accepted Accounting Principles (GAAP) to define the information requested. Contractors regulated by DCBS shall use National Association of Insurance Commission Annual Statement Instructions and Accounting Practices and Procedures. Contractors regulated by DCBS and who have supplied documentation of having a Unique Certificate of Authority Number issued by DCBS may submit the completed Health Maintenance Organization filing or Health form filing provided to DCBS in lieu of submitting Reports G.7, G.8, and G.9 provided they include an OHP Contract column on the "Statement of Revenue and Expense".

**e.** Contractor shall immediately notify DMAP of a Material Change in circumstance from the information contained in the latest-submitted Quarterly Financial Reports. If the Material Change in circumstances requires restatement of prior Quarterly Financial Reports, Contractor shall amend the Quarterly Financial Reports and submit to DMAP within 15 working days of the date the Material Change is identified.

**f.** Reports annotated as an annual requirement only will include all data from the prior calendar year and are due on the dates specified on the reports.

**4. Provider Capacity Report:**

Contractors shall submit, in an electronic format acceptable to DMAP, a Provider Capacity Report, including the information specified in Exhibit K of this Contract. The Provider Capacity Report shall be submitted to DMAP by March 31st each year(s) this Contract is in effect and will include the Contractor's Provider panel as of January 1st of the calendar year.

**5. Assumption of Risk/Private Market Reinsurance:**

Contractor assumes the risk for providing the Capitated Services required under this Contract. Contractor shall obtain risk protection in the form of stop-loss or reinsurance coverage against catastrophic and unexpected expenses related to Capitated Services to DMAP Members.

**a.** If Contractor is a Federally Qualified Health Maintenance Organization, no stop-loss or reinsurance is required for purposes of this Contract, and Contractor shall submit Report G.2 indicating that no reporting under Report G.2 is required.

**b.** Contractor shall submit Report G.2, Part I, of Exhibit G along with the Quarterly Financial Reports, due May 15th, August 15th, November 15th and March 31st. Contractor shall report DMAP Members approaching or surpassing the deductible amount of stop-loss or reinsurance. Report G.2 contains instructions necessary to complete the form.

**c.** At the time of application, or within 30 days of signing this Contract, and thereafter at the time of filing the second Quarterly Financial Report on August 15th, Contractor shall report to DMAP on Report G.2, Part II, of Exhibit G, the deductible amounts and the amount and associated type of stop-loss or reinsurance coverage (e.g., hospital, medical or aggregate coverage), and the dollar amount or percentage of Claim amount whereby responsibility for covering the Claim reverts back to the Contractor from the re-insurer.

**6. Evidence of General and Professional Liability Insurance Coverage:**

Contractors shall obtain and maintain during the term of this Contract insurance coverage as discussed below and provide verification upon DMAP's request:

**a.** **Professional Liability Insurance** - Contractor shall maintain, and shall require that all persons and entities performing services under this Contract (except Oregon Licensed Direct Entry Midwives, of whom professional liability insurance is not required) obtain and keep in effect during the term of this Contract, professional liability insurance which provides coverage of direct and vicarious liability relating to any damages caused by an error, omission or any negligent acts related to the professional services provided under this Contract. Contractor shall maintain and shall require coverage of not less than the amount of $1,000,000 per person per incident and $1,000,000 in the aggregate.

**b.** **General Liability Insurance -** Contractor shall obtain and maintain General Liability insurance with a combined single limit, or the equivalent, of not less than $1,000,000, each occurrence for Bodily Injury and Property Damage. The policy shall be endorsed to also include contractual liability coverage for the Indemnity provided under this Contract. The policy shall provide that the State of Oregon, Department of Human Services, Division of Medical Assistance Programs, and its officers and employees are Additional Insured's but only with respect to Contractor's services to be provided under this Contract.

**7. Restricted Reserve Requirement:**

Contractors, unless exempt, shall establish: 1) Restricted Reserve Account and 2) maintain adequate funds in this account to meet DMAP's Primary and Secondary Restricted Reserve requirements. Reserve funds are held for the purpose of making payments to Providers in the event of the Contractor's insolvency. The reserves discussed within this Contract cover only Capitated Services provided by Contractor notwithstanding Restricted Reserve amounts required to be maintained pursuant to separate contracts with the Department of Human Services.

**Contractors Exempt from the Restricted Reserve Requirement:** Contractor regulated by DCBS and who provides evidence of a unique Certificate of Authority Number issued by DCBS is not required to establish a Restricted Reserve Account or maintain Primary and Secondary Restricted Reserves as set forth by DMAP. Contractor shall indicate on the Quarterly Financial Report G.1 that no documentation is required and shall submit to DMAP annually, on August 31st, a copy of the Unique Certification of Authority Number with documentation showing the type and amount of additional assets required by DCBS.

**a. Restricted Reserve Account:** Contractor shall establish a Restricted Reserve Account with a third party financial institution for the purpose of holding Contractor's Primary and Secondary Restricted Reserve Funds. Contractors shall use the Model Depository Agreement to establish a Restricted Reserve Account.

**(1) Model Depository Agreement** shall be used by the Contractor to establish a Restricted Reserve Account. Contractor shall request the Model Depository Agreement form from DMAP. Contractor shall submit the Model Depository Agreement to DMAP at the time of application and the Model Depository Agreement shall remain in effect throughout the period of time that this Contract is in effect. The Model Depository Agreement cannot be changed without the Administrator or his/her designee's written authorization.

**(2) Withdrawal of Funds from a Restricted Reserve Account:** The Contractor shall not withdraw funds, change third party financial institutions, or change account numbers within the Restricted Reserve Account without the written consent of the Administrator of DMAP or his/her designee.

**(3) Filing requirements:** Contractor shall submit a copy of the Model Depository Agreement at the time of application. If Contractor requests and receives written authorization from the Administrator of DMAP or his/her designee to make a change to their existing Restricted Reserve Account, Contractor shall submit a Model Depository Agreement reflecting the changes to DMAP within 15 days of the date of the change.

**(4) Eligible Deposits:** The following instruments are considered eligible deposits for the purposes of DMAP's Primary and Secondary Restricted Reserves:

**(a)** Cash,

**(b)** Certificates of Deposit,

**(c)** Amply secured obligations of the United States, a state or a political subdivision thereof as determined by DMAP, or

**(d)** A Surety Bond provided it meets the requirements listed below:

**(i)** Such a bond is prepaid at the beginning of the Contract Year for 18 months;

**(ii)** Evidence of prepayment is provided to DMAP;

**(iii)** The Surety Bond is purchased by a surety bond company approved by the Oregon Insurance Division;

**(iv)** The Surety Bond Agreement contains a clause stating the payment of the bond will be made to the third party entity holding the Restricted Reserve Account on behalf of the contracting company for deposit into the Restricted Reserve Account;

**(v)** The Surety Bond Agreement contains a clause that no changes to the Surety Bond Agreement will occur until approved by the DMAP Administrator or his/her designee; and

**(vi)** DMAP approves the terms of the Surety Bond Agreement.

**b. Primary and Secondary Restricted Reserves:** Contractor's Primary and Secondary Reserve balances are determined by calculating the Average Fee-For-Service Liability for Capitated Services using either of the following methods: A) Enrollment Data, or B) Historical Expense Data. The Average Fee-For-Service Liability represents the cost of Covered Services that are offered by the Contractor to DMAP Members that would be owed to creditors in the event of the Contractor's insolvency. These are expenditures for Covered Services for which Contractor is at risk. These services may include out-of-area services, primary care services, referral services, and hospital services. Determination of the cost is based on the usual and customary fee schedule of Contractor that has been developed to approximate the estimated Capitated Service liability of the Contractor. Contractor shall deposit into the Restricted Reserve Account the amount required by Paragraph (3) and (4), of this subsection.

**(1) Average Fee-For-Service Liability based on Enrollment Data:** If Contractor elects to calculate reserve balances based on Enrollment Data, Contractor shall complete Report G.1, Part I and II. The Average Fee-For-Service Liability is calculated by multiplying the Average Capitation Rate times the Average Monthly Enrollees times the Medical Loss Ratio, as follows:

Step 1: Enter the following data:

Capitation Rates: Capitation Rates received for each month of the calendar quarter, Exhibit C, Attachment 2. If Contractor provides services in more than one service area, use the capitation rate for the service area with the largest number of monthly enrollees in the third month.

DMAP Members Enrolled: DMAP Members eligible for full month added to the prorated number of DMAP Members enrolled for less than a month.

Medical Loss Ratio (Restricted Reserve): Contractor may elect to use either the Adjusted or Unadjusted Medical Loss Ratio, whichever method Contractor elects to use to determine the Medical Loss Ratio shall be used throughout the Contract Year. The Medical Loss Ratio is determined for purposes of calculating the fee-for-service liability:

Step 2: Determine the Medical Loss Ratio (Restricted Reserve):

**(a)** Restricted Reserve, Adjusted Medical Loss Ratio:

| | |
|---|---|
| | Total Medical and Hospital Expenses, (Report G.8, Line 21) |
| Less: | Subcapitation or Salaried Medical Expenses (Report G.10.II, Columns A, C, D, E, F and G) |
| Divided by: | Total Revenue (Report G.8, Line 7) |

**(b)** Restricted Reserve, Unadjusted Medical Loss Ratio:

| | |
|---|---|
| | Total Medical and Hospital Expenses, (Report G.8, Line 21) |
| Divided by: | Total Revenue (Report G.8, Line 7) |

Step 3: Calculate the Average Fee-For-Service Liability. The Excel spreadsheet provided by DMAP will calculate the following:

| | |
|---|---|
| | Average Capitation Rate |
| Times: | Average DMAP Members Enrolled |
| Times: | Medical Loss Ratio. |
| Equals: | Average Fee-For-Service Liability |

**(2) Average Fee-for-Service Liability based on Historical Expense Data:** If Contractor has submitted Report G.8, Quarterly Statements of Revenue, Expenses, and Net Worth under this Contract for the current quarter and the prior 3 quarters, Contractor is eligible to use the Historical Expense Data method. The Average Fee-For-Service Liability is an average of the prior four (4) quarters Historical Expense Data. No form has been provided. DMAP will calculate a Contractor's Average Fee-For-Service Liability using the Historical Method as follows:

**(a)** Average of: (current quarter plus 3 prior quarters) Medical/Hospital/Dental Expenses Less Deduction (Report G.8 Line 21),

**(b)** Average (current quarter plus 3 prior quarters) Capitation Payment Expenses (Report G.10.II, Columns C, D, E, F and G); Plus: Salary Service Payment Expenses (Report G.10.II, Column A).

**(c)** Subtract line 2 from line 1.

**(d)** Divide line 3 by the number of months in a quarter or 3.

**(3)** **Determine Primary Reserve**: If Contractor's Average Fee-For-Service Liability is less than or equal to $250,000, Contractor shall deposit into the Restricted Reserve Account an amount equal to the Average Fee-For-Service Liability from Report G.1 of this Exhibit G. This amount will be referred to as the Contractor's Primary Reserve and Contractor shall have no Secondary Reserve, until such time as the Average Fee-For-Service Liability exceeds $250,000.

**(4)** **Determine Secondary Reserve**: If Contractor's Average Fee-For-Service Liability is greater than $250,000, Contractor is required to deposit into the Restricted Reserve Account funds equaling 50 percent of the difference between the Average Fee-For-Service Liability less the Primary Reserve balance of $250,000.

**8. Net Worth Requirements:**

Contractors shall maintain a level of Net Worth that will provide for minimum adequate operating capital. A minimum adequate level of Net Worth is defined as the Discounted Premium Revenue to Net Worth ratio less than or equal to 20:1 (premium to surplus ratio). Contractor shall maintain the Minimum Net Worth level, as determined by this section, during the next calendar quarter. Contractors regulated by DCBS shall follow the Insurance Code and Risk Based Capital Standards.

**a.** **Minimum Net Worth level:** Contractor shall calculate the Minimum Net Worth level by following the steps outlined below:

Step 1: Determine Average Corporate Premium:

| | |
|---|---|
| | Corporate Premium Revenue for the current period |
| Add: | Corporate premium revenue for the prior period |
| Divided by: | 2 |

Step 2: Determine Annualized Average Corporate Premium:

| | |
|---|---|
| | Average Corporate Premium |
| Times: | four (4) |

Step 3: Determine Adjusted Annualized Average Corporate Premium:

| | |
|---|---|
| | Annualized Average Corporate Premium |
| Times: | Medical Loss Ratio (Net Worth), see Step 4, below. |

Step 4: Determine the Medical Loss Ratio (Net Worth):

| | |
|---|---|
| | Medical/Hospital Expense Subtotal (Report G.8, Line 16) |
| Less: | Subcapitation or salaried medical expenses (Report G.10.II, Columns A, C, D, E, F and G) |
| Divided by: | Total Revenue (Report G.8, Line 7) |

Step 5: Determine the Minimum level of Net Worth:

| | |
|---|---|
| | Adjusted Annualized Average Corporate Premium: |
| Divided by: | Twenty (20) |

**b.** Contractor is required to retain a dollar amount no less than 2 percent of Contractor's Adjusted Quarterly Corporate Premium Revenues as retained earnings each subsequent quarter until Contractor has a premium to surplus ratio that meets the 20:1 requirement.

**c.** Contractor shall immediately notify DMAP of a Material Change in circumstance from the information contained in the latest-submitted Quarterly Financial Reports G.8 and G.10. If DMAP determines that a Contractor's premium to surplus ratio does not meet the required premium to surplus ratio level of 20:1, DMAP will notify Contractor.

**9. Physician Incentive Regulation:**

Contractor shall disclose to DMAP information about Physician Incentive arrangements with Providers. If Contractor utilizes compensation arrangements placing Physicians or Physician Groups at Substantial Financial Risk (SFR), as defined in Exhibit M, they must assure provision of adequate stop-loss protection and conduct beneficiary surveys.

**a.** Contractors shall submit either the CMS Physician Incentive Plan (PIP) Disclosure Form (OMB No.0938-0700), see web site: http://www.cms.hhs.gov/manuals/downloads/mc86c06.pdf or the Physician Incentive Plan Disclosure Form, Report G.12 in this Exhibit G, to DMAP no later than August 31st of each year that this Contract is in effect. If any of the information that forms the basis for determining SFR, as defined in Exhibit M, is eliminated, changed, or modified in any manner, Contractor shall immediately notify DMAP. It is expected that all contractual levels in place between the Contractor and any Physician or Physician Group providing services to DMAP Members shall be disclosed.

**b.** Contractors who are regulated by DCBS and disclose PIP information electronically to CMS shall submit to DMAP a copy of the information submitted to CMS. Upon the request of DMAP, Contractor shall submit documentation in enough detail for DMAP to determine if Contractor has transferred SFR. If any of the information that forms the basis for determining SFR, as defined in Exhibit M, is eliminated, changed, or modified in any manner, Contractor shall immediately notify DMAP. It is expected that all contractual levels in place between the Contractor and any Physician or Physician Group providing services to DMAP Members will be disclosed.

**10. Appeal Process:**

If at any time, DMAP believes that Contractor has incorrectly computed the amount of either its Primary or Secondary Restricted Reserve fund, or that Contractor's premium to surplus ratio does not meet the required premium to surplus ratio level of 20:1, DMAP will notify Contractor in writing. In the event that DMAP believes that the Primary or Secondary Restricted Reserve fund has been incorrectly computed, DMAP will notify Contractor of the amount Contractor must maintain as its new Restricted Reserve fund and the basis on which such decision was made. In the event that DMAP believes that Contractor's premium to surplus ratio is below the 20:1 ratio, DMAP will notify Contractor of the dollar amount of no less that 2 percent of its Adjusted Quarterly Premium Revenue required to be retained each subsequent quarter until Contractor has a premium to surplus ratio that meets the 20:1 requirement.

**a.** Within 30 calendar days of any notice by DMAP under this Section, Contractor shall either:

**(1)** Adjust its Restricted Reserve funds to the amount specified by DMAP and provide DMAP with a copy of the restrict reserve statement and updated Schedule A showing the Restricted Reserve balance, adjust its Net Worth to the amount specified by DMAP and provide assurances to DMAP that it is now maintaining that amount as its Net Worth, or

**(2)** File an appeal in writing with the DMAP Administrator stating in detail the reason for the appeal, and submit detailed financial records that support the alternate amount.

**(3)** If Contractor files an appeal, the DMAP Administrator or designee shall issue an appeal decision within 45 calendar days of the receipt of the appeal. That decision shall be binding upon Contractor and not subject to further appeal.

**b.** All information to be reported by Contractor under the requirements of this Exhibit shall be sent to:

MCO Financial Solvency Program Coordinator
Delivery Systems Unit, 3rd Floor E-35
Division of Medical Assistance Programs
500 Summer Street NE
Salem, OR 97301-1077

**11. Glossary of Terms:**

**a.** **Average Capitation Rate** - calculation obtained from Report G.1 which represents Contractor's average OHP Capitation Rate paid per DMAP Member during the quarter.

**b.** **Average Monthly Enrollee** - calculation, obtained from Report G.1, which represents Contractor's average number of DMAP Members enrolled during the quarter.

**c.** **Average Fee-For-Service Liability** - The Average Monthly Fee-For-Service Liability is the cost of health care services that are offered by Contractor to DMAP Members that would be owed to creditors in the event of Contractor's insolvency. These are expenditures for health care services for which Contractor is at risk and will vary in type and amount. These services may include out-of-area services, primary care services, referral services, and hospital services. Determination of the cost is based on the usual and customary fee schedule of Contractor and is developed for the anticipated Capitated Services liability. Anticipated monthly non-service liabilities (such as insolvency insurance, hold harmless contracts liabilities, regulated and non-regulated guarantees liabilities, and other liabilities) are not included.

**d.** **Catastrophic stop-loss** - a mechanism by which Contractor obtains reinsurance coverage against catastrophic and unexpected expenses related to Capitated Services to DMAP Members. Catastrophic stop-loss is different from the stop-loss protection that maybe required under Exhibit M related to Physician Incentive Plan Regulation Guidance.

**e.** **Certification** - statement signed by Contractor or its representative attesting to the accuracy of the reported information.

**f.** **Contractor** - a PHP that contracts with DMAP to provide services under the OHP.

**g.** **Corporation** - a for-profit or not-for-profit organization authorized to conduct business as a corporation in Oregon.

**h.** **Corporate Activity** - the financial position of a corporation relating to activities the corporation performs. Includes the OHP line of business. Any PHP not a corporation should regard its total PHP business as corporate activity.

**i.** **Enrollment Year** - A twelve month period beginning the first day of the month of enrollment of the DMAP Member and, for any subsequent year(s) of continuous enrollment, that same day in each such year(s). The Enrollment Year of DMAP Members who re-enroll within a calendar month of Disenrollment shall be counted as if there were no break in enrollment.

**j.** **Financial information typically computed on a total corporate business only shall be apportioned to reflect the proportion of corporate business that is reflected by the total DMAP Member Capitation Payment during the quarter** - allocation of financial information by the indirect method which allocates costs by departments ignoring any services rendered by department to each other and assumes no reciprocal services exist.

**k.** **Financial solvency** - the collection of resources belonging to a company and the sources of these resources or claims on them at a particular point of time.

**l.** **Hospital Stop-Loss** - those Claims that are covered by Contractor’s hospital stop-loss insurance.

**m.** **IBNR** - incurred but not reported losses is an estimate for Claims which have been incurred as of the last date of the report period for which Contractor is responsible but has not yet determined the specific amount of liability.

**n.** **Intermediary** - a person, corporation or other business entity that performs, by contracting with a Contractor, administrative services for that Contractor or a person, corporation or other business entity that is not regulated by DCBS or by DMAP and arranges, by contracts with physicians and other Providers, to deliver health services for a Contractor and its enrollees via a separate contract between the intermediary and the MCO. Includes affiliates of the Contractor. The payment for such services may vary from payment of a management fee based on a percent of the Contractor's revenue or expenses to a per capita system. A Contractor paying a fiscal intermediary for administrative services must report the actual costs of the appropriate expense classification in the second column or can allocate the costs of the appropriate expenses classification as if the costs had been paid directly by the Contractor.

**o.** **Licensed health entities** - those Contractors who have a unique Certificate of Authority issued by DCBS as licensed Health Service Corporations, Dental Service Corporations, Vision Services Corporations, and Health Maintenance Organizations.

**p.** **DMAP Member** - A DMAP Client enrolled with Contractor in accordance with the OHP Contract.

**q.** **OHP Business** - activities Contractor performs that relate to this Contract.

**r.** **Medical Loss Ratio, Restricted Reserve** - represents that portion of total medical and hospital expenditures after reinsurance recoveries incurred, co-payments, COB and Subrogation for Covered Services to DMAP Members, either unadjusted or adjusted for medical sub-capitation expenditures, divided by total OHP Revenues for which Contractor is at risk.

**s.** **Medical Loss Ratio, Net Worth** - represents that portion of total medical and hospital expenditures before reinsurance recoveries incurred, co-payments, COB and Subrogation for Covered Services to DMAP Members, adjusted for medical sub-capitation expenditures, divided by total OHP Revenues for which Contractor is at risk.

**t.** **Medical Stop-Loss** - those Claims covered by Contractor’s medical stop-loss insurance.

**u.** **National Association of Insurance Commissioners (NAIC)** – an organization that develops standardized procedures and definitions used by the insurance industry. For Exhibit G, the NAIC procedures are those applicable to the Report Period, pursuant to DCBS requirements.

**v.** **NAIC "Annual Statement for Health Maintenance Organizations"** - the model reporting provisions developed by the National Association of Insurance Commissioners and referred to as the Official NAIC Annual Statement Blank, Health Maintenance Organizations.

**w.** **NAIC "Annual State Instructions for Health Maintenance Organizations"** - the accounting guidelines and annual statement instructions relating to health maintenance organizations published by NAIC.

**x.** **NAIC "Health Annual Statement"** - the model reporting provisions developed by the National Association of Insurance Commissioners and referred to as the Official NAIC Health Annual Statement. These reporting provisions are also used for annual and quarterly reporting by licensed health entities.

**y.** **NAIC "Health Annual State Instructions"** - the accounting guidelines and annual statement instructions relating to licensed health entities and referred to as the instructions to the Official NAIC Health Annual Statement. These reporting provisions are also used for both annual and quarterly reporting by licensed health entities.

**z.** **OHP** Activity - the financial position of Contractor relating to activities that Contractor performs that are associated with Capitated Services provided under this Contract.

**aa.** **Provide quarterly** - submitted four times a calendar year with information compiled over three months (i.e., January-March information submitted by May15th; April-June information submitted by August 15th; July-September information submitted by November 15th; October-December information submitted by March 31st).

**bb.** **Quarterly Financial Reports** - accounting information covering a calendar quarter (i.e., January through March, April through June, July through September, and October through December) used to show significant relationships about the resources belonging to a company and the sources of these resources that facilitates comparisons from period to period and among lines of businesses or companies.

**cc.** **Receipt of the appeal** - the date that the appeal document is delivered to DMAP, Analysis & Evaluation Unit and is date-stamped.

**dd.** **Receipt of the information** - the date that the information is delivered to DMAP Administrator.

**ee.** **Report period** - the period of time the information in each report covers. This period is derived from the requirements found in the OHP Contract. Use only those Claims paid in the report period, except where noted on Report G.4. The date a Claim is paid is determined by the Claims paid date or by the encounter data process date.

**ff.** **Risk-sharing intermediaries** - a person, corporation or other business entity that is not regulated by DCBS or by DMAP and for whom the Contractor has made arrangements to lessen the fee-for-service liabilities within its contract with that person, corporation or other business entity by requiring the retainment of risk.

**gg.** **Statement of Actuarial Opinion** - a statement prepared by a qualified health maintenance organization actuary setting forth his or her opinion relating to loss reserves, provision for experience rating refunds, and any other actuarial or accounting

items in accordance with the description of Actuarial Certification found in the NAIC "Annual Statement Instructions, Health Maintenance Organization" or the "Annual Health Statement".

**hh. Stop-Loss deductible** - the amount of stop-loss protection obtained by Contractor to meet the requirement in the OHP Contract.

**ii. Total DMAP Member Months** - the sum of the enrollment in the PHP for each month during the report period. Individuals enrolled for less than a month will be prorated.

**12. Instructions for Completing Reports G.1 – G.12 and FORM G.1**

**a. Report G.1: Restricted Reserve**

NOTWITHSTANDING ANY DEFINITIONS IN THIS CONTRACT THAT MAY BE INCONSISTENT, THE FOLLOWING DEFINITIONS APPLY ONLY FOR PURPOSES OF EXPLAINING THE REQUIREMENTS OF THIS REPORT G.1. THE NUMBERED TERMS SET FORTH BELOW CORRESPOND WITH THE NUMBERS OR HEADINGS ON THE REPORT G.1**.**

**General:**

Form G.1 certifies all information submitted is accurate, complete, and truthful. It is to be completed and signed by an authorized representative of Contractor. The original certificate is to be mailed to DMAP.

Report G.1 is one of the Quarterly Financial Reports and shall be submitted to DMAP in accordance with Section 3 of this Exhibit G. Contractors shall use Report G.1 for the purposes of determining: 1) Average Fee-For-Service Liability using Enrollment Data and 2) Primary and Secondary Restricted Reserve requirements as required by Section 7 of this Exhibit G.

**Instructions:**

**Column 3** - Capitation Rate - the amount DMAP pays on a per member per month basis to Contractor in advance of and as payment for the DMAP Member's actual receipt of services. If Contractor provides services in more than one Service Area, use the Capitation Rate for the Service Area with the largest number of monthly enrollees in the third month.

**Average Capitation Rate** - sum of (Column 3, Capitation Rate (times) Column 4, Monthly Enrollees) divided by (Average Monthly Enrollees) divided by (number of months in the quarter).

**Column 4** - Monthly Enrollees - the number of DMAP Members eligible for full month added to the prorated number of individuals enrolled for less than a month. Monthly enrollees shall be reported in decimal form rounded to the nearest 100th.

**Average Monthly Enrollees** - sum of Column 4, Monthly Enrollees (divided by) the number of months in the quarter.

**Column 5** - Medical Loss Ratio - Contractor shall elect to use either an unadjusted or adjusted Medical Loss Ratio.

**(1) Medical Loss Ratio, (Restricted Reserve) unadjusted:** The Medical Loss Ratio can be no lower than .2 to leave adequate monies for administrative expenses and net income.

| | |
|---|---|
| | HP Medical and Hospital Expenses Less Deductions (Line 21, Report G.8) |
| divided by: | OHP Total Revenues (Line 7, Report G.8) |

**(2) Medical Loss Ratio, (Restricted Reserve) adjusted** - The Medical Loss Ratio can be no lower than .2 to leave adequate monies for administrative expenses and net income.

| | |
|---|---|
| | HP Medical and Hospital Expenses Less Deductions (Line 21, Report G.8) |
| less: | OHP Salary payments (Column A, Report G.10) |
| less: | OHP Subcapitation payments (Columns C, D, E, F and G; Report G.10) |
| divided by: | OHP Total Revenues (Line 7, Report G.8) |

**Column 6** - Fee-For-Service Liability for Capitated Services - Column 3, Capitated Rate (times) Column 4, Monthly Enrollees (times) Column 5, Medical Loss Ratio, (Restricted Reserve).

**Average Fee-For-Service Liability** - Column 3, Average Capitation Rate (times) Column 4, Average Monthly Enrollee (times) Column 5, Medical Loss Ratio.

**b. Report G.2: DMAP Members Approaching or Surpassing Stop-Loss Deductible**

NOTWITHSTANDING ANY DEFINITIONS IN THIS CONTRACT THAT MAY BE INCONSISTENT, THE FOLLOWING DEFINITIONS APPLY ONLY FOR PURPOSES OF EXPLAINING THE REQUIREMETNS OF THIS REPORT G.2. THE NUMBERED TERMS SET FORTH BELOW CORRESPOND WITH THE NUMBERS OR HEADINGS ON THE REPORT G.2.

**General:**

Report G.2 is one of the Quarterly Financial Reports and shall be submitted to DMAP in accordance with Section 3 of this Exhibit G. This information is used by DMAP to assess the catastrophic stop-loss exposure of each contractor.

**Instructions:**

**Part I** - Contractor shall submit Part I of Report G.2 to DMAP quarterly on May 15th, August 15th, November 15th and March 31st. Contractor shall provide the following information about the number of DMAP Members whose costs on approved health care Claims are within the range of stop-loss deductible for the calendar quarter.

**Part II** - Contractors shall complete Part II of Report G.2, annually and submit on August 31st. Provide answers to the question about Contractors reinsurance. Provide one report for each reinsurer.

**c. Report G.3: OHP Key Utilization Indicators**

This report has been rescinded by DMAP and Contractor is no longer required to file this report as part of the Exhibit G, Quarterly Financial Reports.

**d. Report G.4: OHP Access to Services**

NOTWITHSTANDING ANY DEFINITIONS IN THIS CONTRACT THAT MAY BE INCONSISTENT, THE FOLLOWING DEFINITIONS APPLY ONLY FOR PURPOSES OF EXPLAINING THE REQUIREMENTS OF THIS REPORT G.4. THE NUMBERED TERMS SET FORTH BELOW CORRESPOND WITH THE NUMBERS OR HEADINGS ON THE REPORT G.4.

**General:**

Report G.4 is one of the Quarterly Financial Reports and shall be submitted to DMAP in accordance with Section 3 of this Exhibit G.

**Instructions:**

**(1) Usage of Services:**

**(a)** DMAP Members enrolled during the Prior Quarter with Claims Paid - the number of unduplicated DMAP Members enrolled in the prior quarter for whom Claims had dates of service occurring in the prior report period and whose Claims were paid in the prior or current report quarter.

**(b)** DMAP Members enrolled during the Prior Quarter with unpaid Claims - the number of unduplicated DMAP Members enrolled in the prior quarter for whom there were no paid Claims having dates of service occurring in the prior report period or for whom there were Claims with a date of service occurring in the prior report quarter, but no paid date in the prior or current report quarter.

**(c)** Total number of DMAP Members enrolled in Prior Quarter - the sum of Line 1 and Line 2 will equal DMAP Members enrolled during the Prior Quarter. Contractor shall verify that this number is equal to the amount from the prior period Report G.4 (III Membership Line 3 of either part A or B).

**(2) Membership:**

Use Member's primary insurance to define which policy type (Group, Medicare, Individual, etc.) is associated with the Member. Contractor shall report total number of Members currently enrolled in their plan on the last day of the reporting period. Contractor shall provide membership information for each policy type. Entities regulated by DCBS (use Section A of this report) - any Contractor with a unique Certificate of Authority number issued by DCBS. Entities not regulated by DCBS (use Section B of this report) - any Contractor without a unique Certificate of Authority number issued by DCBS. Contractor shall provide the following membership information:

**(a)** **Members with Group Policies** - the number of Members who are enrolled in group policies where the premiums are determined as a group rate. Excludes Members counted in other lines.

**(b)** **Members with Medicare Policies** - the number of Members who are enrolled in Medicare policies. Excludes Members counted in other lines.

**(c)** **Members covered by this Contract** - the number of DMAP Members enrolled with Contractor in accordance with this Contract. Excludes Members counted in other lines.

**(d)** **Medicaid Members Other than DMAP Members** - the number of Members whose health care costs are covered by Medicaid but are not DMAP Members covered by this Contract. Excludes Members counted in other lines.

**(e)** **Members with Individual Policies** - the number of Members whose health care premiums are paid by an individual. Excludes Members counted in other lines.

**(f)** **Other Members** - all other Members who do not fall into one of the previous mentioned categories. Excludes Members counted in other lines.

**(g)** **Total Members** - the total number of Members enrolled with Contractor on the last day of the report period. Use Member's primary insurance for purposes of reporting which policy type is associated with the Member. Each Member enrolled with Contractor shall not be reported more than once.

**e. Report G.5: Audited Yearly – Balance Sheet of Corporate Activity**

NOTWITHSTANDING ANY DEFINITIONS IN THIS CONTRACT THAT MAY BE INCONSISTENT, THE FOLLOWING DEFINITIONS APPLY ONLY FOR PURPOSES OF EXPLAINING THE REQUIREMETNS OF THIS REPORT G.5. THE NUMBERED TERMS SET FORTH BELOW CORRESPOND WITH THE NUMBERS OR HEADINGS ON THE REPORT G.5.

**General:**

Contractor shall include information specified in Report G.5 and file Report G.5 in accordance with Section 2 of this Exhibit G. Contractor shall report in the column labeled Corporate Activity the Contractor's financial information of a for-profit or not-for-profit corporation, which is not a foreign corporation, incorporated under or subject to the provisions of Chapter 60 and ORS 732.005 of the Oregon Insurance Code. If Contractor is not a corporation, Contractor shall report its total PHP business in the column labeled Corporate Activity.

**Contractor shall provide Details of Write-Ins** - Any item which is a component of any other line, is greater than 10% of the amount on the Subtotal Line (lines 9, 17, 23, 32, 37 and 47), and whose value is greater than $1,000 will need to be described on these lines and the amount of the item disclosed. On the description line please reference the line number of the Other Line (i.e. Line 8, 16, 22, 31, 36 or 46), identify the expense and disclose the amount of expense claimed.

**Instructions:**

**(1) Cash and Cash Equivalents** - cash in the bank or on hand, available for current use. Cash equivalents are investments maturing 90 days or less from date of purchase.

**(2) Short-term Investments** - investments in securities that are readily marketable, maturing one year or less from date of purchase.

**(3) Premiums Receivable** - gross amounts collectible from premiums receivable (groups or individuals who receive services from Contractor, less the amount accrued for premiums determined to be uncollectible).

**(4) Investment Income Receivables** - income earned on investments but not received

**(5) Health Care Receivables** - gross amounts collectible from other sources, less the amount accrued for receivables determined to be uncollectible during the period. Includes fee-for-service, TPR, COB, subrogation, co-payments, reinsurance recoveries and non-affiliated Provider receivables.

**(6)** **Amounts Due from Affiliates** - any receivable from an affiliate or a person affiliated with, a specific person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

**(7)** **Reinsurance Recoverable on Paid Losses** - any receivable from a reinsurer for monies already paid for reinsurance coverage.

**(8)** **Other Current Assets** - other current assets, such as aggregate write-ins for current assets found on NAIC Report #1.

**(9)** **TOTAL CURRENT ASSETS** - the sum of Line 1 through Line 8.

**(10)** **Bonds** - bonds with a maturity longer than one year from date of purchase that must be valued at the book value, defined as the amortized or market value.

**(11)** **11.1** **Preferred stocks** - preferred stock investments that are considered long-term invested assets.

**11.2** **Common stocks** - common stock investments that are considered long-term invested assets.

**(12)** **Other Long-Term Invested Assets** - other investments with a maturity date more than one year from date of purchase or no stated maturity date.

**(13)** **Receivable for Securities** - amounts received within 15 days of the end of the reporting period, due from brokers when a security had been sold, but the proceeds have not yet been received.

**(14)** **Amounts Due from Affiliates** - any receivable from an affiliate or a person affiliated with, a specific person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

**(15)** **Restricted Cash and Restricted Securities** - assets restricted for statutory insolvency requirements such as cash, securities, receivables, etc.

**(16)** **Other Assets** - other assets, such as aggregate write-ins for other assets found on NAIC Report #1.

**(17)** **TOTAL OTHER ASSETS** - the sum of Line 10 through Line 16.

**(18)** **Land, Building and Improvements** - real estate owned by Contractor, buildings owned by Contractor, improvements made to Contractor-owned buildings, and building or improvements in progress or under construction.

**(19)** **Furniture and Equipment** - medical equipment, office equipment, and furniture owned by Contractor.

**(20)** **Leasehold Improvements**- improvements to facilities not owned by Contractor. Provide gross amount, less amortization.

**(21)** **EDP Equipment** - EDP hardware and software that constitute a data processing system used by the insurer if the cost of such a system is at least $50,000 and is to be amortized in full in not more than 10 years.

**(22)** **Other Property and Equipment** - other tangible, fixed assets of a long-term nature used in the continuing operation of the business, including land, building, building improvements, furniture, equipment and leasehold improvements not included above.

**(23)** **TOTAL PROPERTY AND EQUIPMENT** - the sum of Line 18 through Line 22.

**(24)** **TOTAL ASSETS** - the sum of Line 9, Line 17, and Line 23.

**(25)** **Accounts Payable** - short-term monetary amounts due to creditors for the acquisition of goods and services (trade and vendors rather than health care practitioners) on a credit basis. Report taxes and payroll taxes on Other Current Liabilities line.

**(26)** **Claims Payable** - Claims reported and booked as payables and IBNR Claims. This liability relates to claims expenses found on the Statement of Revenues, including percentage withholds but excluding medical incentive pool. Include the net of reinsurance ceded. Other categories of liabilities netted into claims payable are 1) Claims recoverable, 2) Unallocated loss reserve, 3) Recoverable on unpaid losses, 4) Monies set aside for claims processing, and 5) Claims adjustment expenses, among others.

**Incurred but Not Reported (IBNR)** - incurred but not reported losses are estimates of claims which have been incurred as of the last date of the report period for which Contractor is responsible but has not yet determined the specific amount of liability.

**(27)** **Accrued Medical Incentive Pool** - liability for arrangements whereby Contractor agrees to share utilization savings with Individual Practice Associations, physician groups, or other Providers.

**(28)** **Unearned Premiums** - revenue received or booked in advance of the reporting period for services that have not been performed during the current accounting period. A liability exists to render service in the future.

**(29)** **Loans and Notes Payable** - the principal amount on loans due within one year.

**(30)** **Amounts Due to Affiliates** - any payable to an affiliate, including items that would otherwise be reported on other lines.

**(31)** **Other Current Liabilities** - current liabilities not included in the current liabilities categories listed above, including MCO tax.

**(32)** **TOTAL CURRENT LIABILITIES** - the sum of Line 25 through Line 31.

**(33)** **Loans and Notes Payable** - loans and notes signed by Contractor, not including current portion payable, that are of a long-term nature (liquidation not expected to occur within one year of the date of the statement).

**(34)** **Amounts Due to Affiliates** - any payable to an affiliate or a person affiliated with, a specific person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified. This line includes items that would otherwise be reported on other lines.

**(35)** **Payable for Securities** - amounts that are due to brokers when a security has been purchased, but has not yet been paid; any payable for securities that is due as of the last date of the report period.

**(36)** **Other Liabilities** - other liabilities not included in the liabilities categories listed above.

**(37)** **TOTAL OTHER LIABILITIES** - the sum of Line 33, Line 34, Line 35 and Line 36.

**(38)** **TOTAL LIABILITIES** - the sum of Line 32 and Line 37.

**(39)** **Common Stock** - the residual interest in the asset of the stock which represents the most basic rights to ownership of a corporation. It should equal the par value per share multiplied by the number of issued shares or in the case of no-par shares, the total stated value.

**(40)** **Preferred Stock** - the residual interest in the asset of stock that has some preference over common stock, usually including dividends; should equal the par value per share multiplied by the number of issued shares, or in the case of no-par shares, the total stated or liquidation value.

**(41)** **Paid in Surplus** - the gross amount of paid in and contributed surplus without reduction of account of commissions or other expenses in connection with such transactions, but reduced by a distribution declared and paid as a return of such surplus.

**(42)** **Contributed Capital** - capital donated to nonprofit organizations.

**(43)** **Surplus Notes** - notes that qualify as equity; also called subordinated debt or debentures. Include accrued interest on surplus notes.

**(44)** **Contingency Reserves**- reserves held for contingency purposes as defined in State statutes and regulations.

**(45) Retained Earnings/Net Worth** - the undistributed and unappropriated amount of surplus.

**(46) Other Net Worth** - other net worth items not reported on any other lines.

**(47) TOTAL NET WORTH** - the sum of Line 39 through Line 46.

**(48) TOTAL LIABILITIES AND NET WORTH** - the sum of Line 38 and Line 47.

**f. Report G.6 – Audited Yearly – Statement of Revenue, Expenses, and Net Worth**

NOTWITHSTANDING ANY DEFINITIONS IN THIS CONTRACT THAT MAY BE INCONSISTENT, THE FOLLOWING DEFINITIONS APPLY ONLY FOR PURPOSES OF EXPLAINING THE REQUIREMENTS OF THIS REPORT G.6. THE NUMBERED TERMS SET FORTH BELOW CORRESPOND WITH THE NUBMERS OR HEADINGS ON THE REPORT G.6.

**General:**

Contractor shall include information specified in Report G.6 and file Report G.6 in accordance with Section 2 of this Exhibit G. Contractor shall report in the column labeled Corporate Activity the Contractor's financial information of a for-profit or not-for-profit corporation that is not a foreign corporation, incorporated under or subject to the provisions of Chapter 60 and ORS 732.005 of the Oregon Insurance Code. If Contractor is not a corporation, Contractor shall report its total PHP business in the column labeled Corporate Activity.

**Contractor shall submit Details of Write-Ins** - Any item which is a component of any other line, is greater than 10% of the amount on the Subtotal Line (i.e. Line 7, 16 or 25), and whose value is greater than $1,000 will need to be described on these lines and the amount of the item disclosed. On the description line please reference the line number of the Other Line (i.e. Line 5, 6, 15, 24 or 38e) identify the expense, and disclose the amount of expense claimed.

**Instructions:**

**(1) Premiums -** revenue recognized (net of reinsurance premium paid to the reinsurer on a prepaid basis from individuals and groups for provision of a specified range of health services over a defined period of time. Include DMAP capitation and Maternity case rate payments and the net of reinsurance premiums ceded. If advance payments are made to Contractor for more than one report period, the portion of the payment that has not yet been earned must be treated as a liability (unearned premiums).

**(2)** **Fee-For-Service** - revenue recognized by Contractor for provision of health services to non-DMAP Members by Contractor practitioners and to DMAP Members through provision of health services excluded from their prepaid benefit packages.

**(3)** **Title XIX-Other Medicaid** - other Medicaid revenues as a result of other non-capitated arrangements between Contractor and a Medicaid State Agency, for services to a Medicaid beneficiary.

**(4)** **Net Investment Income** - income earned from investments, deposits and reserve accounts, including net realized capital gains or losses.

**(5)** **Other Health Care** - Related Revenues - revenue recognized for provision of health services over a defined period of time not included in previous revenue categories.

**(6)** **Non Healthcare-Related Revenues** - other revenues not included in the previous revenue categories.

**(7)** **TOTAL REVENUES** - the sum of Line 1 through Line 6.

**(8)** **Physician/Professional Services** - expenses for physician services provided under contractual arrangement to Contractor including physician salaries, fringe benefits, Capitated Payments paid to physicians, fees paid to physicians on a fee-for-service basis for delivery of medical services, including capitated referrals. Compensations, as well as fringe benefits, paid by Contractor to non-physician practitioners engaged in the delivery of medical services and to personnel engaged in activities in direct support of the provision of medical services. Include expenses for practitioners not under contractual arrangements with Contractor. Exclude expenses for medical personnel time devoted to administrative tasks.

Physician shall be defined to include practitioner who is an allopathic, osteopathic, homeopathic, podiatric, chiropractic, or naturopathic physician, physician assistant, and nurse practitioner.

Professionals include dentists, psychologists, optometrists, nurses, clinical personnel such as ambulance drivers, technicians, paraprofessionals, quality assurance analysts, administrative supervisors and medical record clerks.

**(9)** **Hospital Services**

**(a)** **Inpatient** – Inpatient hospital costs for Contractor members while confined to an acute care hospital, including out of area hospitalization. Include the cost of skilled nursing and intermediate care facilities.

**(b)** **Outpatient –** Outpatient hospital costs for Contractor members not confined to an acute care hospital, including out of area Outpatient services.

**(c)** **Emergency Room** – expenses for emergency room services, including out of area emergency services.

**(10)** **Pharmacy** – retail pharmacy costs, net of rebates and administrative fees.

**(11)** **Lab and X-ray** – independent laboratory and x-ray services for Contractor members.

**(12)** **Vision** - non-medical/routine vision exams and related hardware.

**(13)** **Chemical Dependency** – services provided by alcohol or chemical dependency Providers.

**(14)** **Durable Medical Equipment & Supplies** - independent Providers of DME and Supplies. Equipment that can stand repeated use and is primarily and customarily used to serve a medical purpose and non-reusable medical supply items used in the treatment of illness or injury.

**(15)** **Other (write-ins)** - other expenses for medical and hospital services not included in the above categories, including IBNR costs.

**(16)** **MEDICAL AND HOSPITAL EXPENSES SUBTOTAL** - the sum of Line 8 through Line 15.

**(17)** **Reinsurance Recoveries Incurred** - reinsurance recovered from the reinsurer on paid losses and those amounts that have been billed to the reinsurer and not yet received. Include reinsurance recovered and recoverables on paid losses. Unpaid losses are netted against the appropriate medical and hospital expense lines89 -15. NOTE: this is NOT a net figure.

**(18)** **Co-payments** - revenue recognized by Contractor from members on a utilization-related basis for certain health services included in the benefit package.

**(19)** **TPR, COB, and Subrogation** – income earned from Third Party Recoveries, coordination of benefits, and subrogation.

**(20)** **DEDUCTIONS SUBTOTAL** - the sum of Lines 17 through 19.

**(21)** **TOTAL MEDICAL AND HOSPITAL EXPENSES LESS DEDUCTIONS** - the sum of Line 16 minus Line 20.

**(22)** **Compensation** - Include salaries and wages, bonuses and incentive compensation to employees, overtime payments, continuation of salary during temporary short-term absences, dismissal allowances, payments to employees while in training and other compensation to employees not specifically designated to another expense category. Include fees and other compensation to

directors for attendance at board or committee meetings and any other fees and compensation paid to them in their capacities as directors or committee members. Report agency compensation other than commissions.

**(23)** **Marketing/Educational Materials and advertising -** Expenses directly related to marketing activities. Include such items as 1) newspaper, magazine and trade journal advertising for the purpose of solicitation and conservation of business, 2) all calendars, blotters, wallets, advertising novelties, etc., for distribution to the public, 3) print, paper stock, etc. in connection with advertising, 4) prospect and mailing lists when used for advertising purposes and 4) pamphlets on educational subjects or other member materials specifically relating to the OHP Line of Business. Omit salaries and expenses of advertising department personnel, help-wanted advertisements, and advertising in connection with investments.

**(24)** **Other Administrative Expenses** – payment made for other administrative expenses associated with the overall management and operations of Contractor not included in the above categories.

**(25)** **TOTAL ADMINISTRATIVE EXPENSE** - the sum of items of Line 22 through Line 24.

**(26)** **TOTAL EXPENSES** - the sum of Line 21 and Line 25.

**(27)** **INCOME (LOSS) (before taxes)-** the result of Line 7 minus Line 26.

**(28)** **MCO Tax** – the expense for Managed Care taxes.

**(29)** **Provision for Income Taxes** - the expense for income taxes for the report period.

**(30)** **NET INCOME (LOSS) -** the result of Line 28 minus Line 29 minus Line 30.

**(31)** **Corporate Net Worth Beginning of Year -** the total of common stock, preferred stock, paid in surplus, contributed capital, surplus notes, contingency reserves, retained earnings/fund balance, and other items at the beginning of the report period.

**(32)** **Increase (Decrease) in Common Stock** - the change in the net worth of common stock from the last report period to the current report period.

**(33)** **Increase (Decrease) in Preferred Stock** - the change in the net worth of preferred stock from the last report period to the current report period.

**(34)** **Increase (Decrease) in Paid in Surplus** - the change in the net worth of paid in surplus from the last report period to the current report period.

**(35)** **Increase (Decrease) in Contributed Capital** - the change in the net worth of contributed capital from the last report period to the current report period.

**(36) Increase (Decrease) in Surplus Notes** - the change in the net worth of surplus notes from the last report period to the current report period.

**(37) Increase (Decrease) in Contingency Reserves** - the change in the net worth of contingency reserves from the last report period to the current report period.

**(38) Increase (Decrease) in Retained Earnings/ Net Worth**- the change in the net worth of retained earnings/net worth from the last report period to the current report period.

**(39) Corporate Net Worth at End of Year** - the total of common stock, preferred stock, paid in surplus, contributed capital, surplus notes, contingency reserves, retained earnings/fund balance, and other items at the end of the report period.

**g. Report G.7: Quarterly Financial Report – Balance Sheet of Corporate Activity**

NOTWITHSTANDING ANY DEFINITIONS IN THIS CONTRACT THAT MAY BE INCONSISTENT, THE FOLLOWING DEFINITIONS APPLY ONLY FOR PURPOSES OF EXPLAINING THE REQUIREMENTS OF THIS REPORT G.7. THE NUMBERED TERMS SET FORTH BELOW CORRESPOND WITH THE NUMBERS OR HEADINGS ON THE REPORT G.7.

**General:**

Report G.7 is one of the Quarterly Financial Reports and shall be submitted to DMAP in accordance with Section 3 of this Exhibit G. Contractor shall report in the column labeled OHP Contract Line the expenses associated with providing service to DMAP Members and shall report in the column labeled Corporate Activity the Contractor's total financial information of the for-profit or non-for-profit corporation which is not a foreign corporation, incorporated under or subject to the provisions of Chapter 60 and ORS 732.005 of the Oregon Insurance Code. If Contractor is not a corporation, Contractor shall report in the column labeled OHP Contract Line the expenses associated with providing service to DMAP Members and shall report in the column labeled Corporate Activity the Contractor's total financial information. Amounts appearing on Report G.7 shall equal the total reported annually on Report G.5.

Allocation of expenditures between OHP Contract Line of Business and Corporate Line of Business: If separate accounts are not kept for the OHP, revenue, expenses and net worth information for the OHP shall be allocated using an estimation procedure approved by DMAP. Such a procedure and all assumptions must be disclosed in Notes to Report G.7. This estimation procedure must be used throughout the reports. The assumptions underlying the allocation must be based on a methodology that clearly represents the true costs associated with providing services to DMAP Members.

**Contractor shall submit a Details of Write-Ins for** - Any item which is a component of any other line, is greater than 10% of the amount on the Subtotal Line (i.e. Line 9, 17, 23, 32, 37 or 47), and whose value is greater than $1,000, must be described on

these lines and the amount of the item disclosed. On the description line, please reference the line number of the Other Line (i.e. Line 8, 16, 22, 31, 36 or 46), identify the expense, and disclose the amount of expense claimed.

**Instructions:**

**(1)** **Cash and Cash Equivalents** - cash in the bank or on hand, available for current use. Cash equivalents are investments maturing 90 days or less from date of purchase.

**(2)** **Short-term Investment** - investments in securities that are readily marketable, maturing one year or less from date of purchase.

**(3)** **Premiums Receivable** - gross amounts collectible from premiums receivable (groups or individuals who receive services from Contractor, less the amount accrued for premiums determined to be uncollectible).

**(4)** **Investment Income Receivables** - income earned on investments but not received

**(5)** **Health Care Receivables** - gross amounts collectible from other sources, less the amount accrued for receivables determined to be uncollectible during the period. Includes fee-for-service, TPR, COB, subrogation, co-payments, reinsurance recoveries and non-affiliated Provider receivables.

**(6)** **Amounts Due from Affiliates** - any receivable from an affiliate or a person affiliated with, a specific person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

**(7)** **Reinsurance Recoverable on Paid Losses** - any receivable from a reinsurer for monies already paid for reinsurance coverage.

**(8)** **Other Current Assets** - other current assets, such as aggregate write-ins for current assets.

**(9)** **TOTAL CURRENT ASSETS** - the sum of Line 1 through Line 8.

**(10)** **Bonds** - bonds with a maturity longer than one year from date of purchase and must be valued at the book value as defined as the amortized or market value.

**(11)** **Stocks:**

**(a)** Preferred stocks - preferred stock investments that are considered long-term invested assets.

**(b)** Common stocks - common stock investments which are considered long-term invested assets.

**(12)** **Other Long-Term Invested Assets** - other investments with maturity longer than one year from date of purchase or no stated maturity date.

**(13)** **Receivable for Securities** - amounts received within 15 days of the end of the reporting period, due from brokers when a security had been sold, but the proceeds had not yet been received.

**(14)** **Amounts Due from Affiliates** - any receivable from an affiliate or a person affiliated with, a specific person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

**(15)** **Restricted Cash and Restricted Securities** - assets restricted for statutory insolvency requirements such as cash, securities, receivables, etc.

**(16)** **Other Assets** - other assets, such as aggregate write-ins for other assets

**(17)** **TOTAL OTHER ASSETS** - the sum of Line 10 through Line 16.

**(18)** **Land, Building and Improvements (net of accumulated depreciation)**- real estate owned by Contractor, buildings owned by Contractor, improvements made to Contractor-owned buildings, and building or improvements in progress or under construction.

**(19)** **Furniture and Equipment (net of accumulated depreciation)** - medical equipment, office equipment, and furniture owned by Contractor.

**(20)** **Leasehold Improvements (net of accumulated depreciation)** - improvements to facilities not owned by Contractor. Provide gross amount, less amortization.

**(21)** **EDP Equipment (net of accumulated depreciation)** - EDP hardware and software that constitute a data processing system used by the insurer if the cost of such a system is at least $50,000 and is to be amortized in full in not more than 10 years.

**(22)** **Other Property and Equipment (net of accumulated depreciation)** - other tangible, fixed assets of a long-term nature used in the continuing operation of the business, including land, building, building improvements, furniture, equipment and leasehold improvements not included above.

**(23)** **TOTAL PROPERTY AND EQUIPMENT** - the sum of Line 18 through Line 22.

**(24)** **TOTAL ASSETS** - the sum of Line 9, Line 17, and Line 23.

**(25)** **Accounts Payable** - short-term monetary amounts due to creditors for the acquisition of goods and services (trade and vendors rather than health care practitioners) on a credit basis.

**(26)** **Claims Payable** - Claims reported and booked as payables and IBNR Claims. This liability relates to Claims expenses found on the Statement of Revenues, including percentage withholds but excluding medical incentive pool. Include the net of reinsurance ceded. Other categories of liabilities netted into Claims payable are 1) Claims recoverable, 2) Unallocated loss reserve, 3) Recoverable on unpaid losses, 4) Monies set aside for Claims processing, and 5) Claims adjustment expenses, among others.

**IBNR** - (Incurred but not reported losses) an estimate for Claims that have been incurred as of the last date of the report period for which Contractor is responsible but has not yet determined the specific amount of liability.

**(27)** **Accrued Medical Incentive Pool** - liability for arrangements whereby Contractor agrees to share utilization savings with Individual Practice Associations, physician groups, or other Providers.

**(28)** **Unearned Premiums** - revenue received or booked in advance of the reporting period for services that have not been performed during the current accounting period. A liability exists to render service in the future.

**(29)** **Loans and Notes Payable** - the principal amount on loans due within one year.

**(30)** **Amounts Due to Affiliates** - any payable to an affiliate, including items that would otherwise be reported on other lines.

**(31)** **Other Current Liabilities** - current liabilities not included in the current liabilities categories listed above. Include taxes, MCO tax, and payroll taxes.

**(32)** **TOTAL CURRENT LIABILITIES** - the sum of Line 25 through Line 31.

**(33)** **Loans and Notes Payable** - loans and notes signed by Contractor, not including current portion payable, that are of a long-term nature (liquidation not expected to occur within one year of the date of the statement).

**(34)** **Amounts Due to Affiliates** - any payable to an affiliate or a person affiliated with, a specific person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified. This line includes items that would otherwise be reported on other lines.

**(35)** **Payable for Securities** - amounts that are due to brokers when a security has been purchased, but has not yet been paid; any payable for securities that is due as of the last date of the report period.

**(36)** **Other Liabilities** - other liabilities not included in the liabilities categories listed above.

**(37)** **TOTAL OTHER LIABILITIES** - the sum of Line 33, Line 34, Line 35 and Line 36.

**(38)** **TOTAL LIABILITIES** - the sum of Line 32 and Line 37.

**(39)** **Common Stock** - the residual interest in the asset of the stock which represents the most basic rights to ownership of a corporation. It should equal the par value per share multiplied by the number of issued shares or in the case of no-par shares, the total stated value.

**(40)** **Preferred Stock** - the residual interest in the asset of stock that has some preference over common stock, usually including dividends; should equal the par value per share multiplied by the number of issued shares, or in the case of no-par shares, the total stated or liquidation value.

**(41)** **Paid in Surplus** - the gross amount of paid in and contributed surplus without reduction of account of commissions or other expenses in connection with such transactions, but reduced by a distribution declared and paid as a return of such surplus.

**(42)** **Contributed Capital** - capital donated to nonprofit organizations.

**(43)** **Surplus Notes** - notes that qualify as equity; also called subordinated debt or debentures. Include accrued interest on surplus notes.

**(44)** **Contingency Reserves** - reserves held for contingency purposes as defined in State statutes and regulations.

**(45)** **Retained Earnings/ Net Worth** - the undistributed and unappropriated amount of surplus.

**(46)** **Other Net Worth** - other net worth items not reported on any other lines.

**(47)** **TOTAL CORPORATE NET WORTH** - the sum of Line 39 through Line 46.

**(48)** **TOTAL LIABILITIES AND NET WORTH** - the sum of Line 38 and Line 47.

**h. Report G.8: Quarterly Financial Report – Statement of Revenue, Expenses and Net Worth:**

NOTWITHSTANDING ANY DEFINITIONS IN THIS CONTRACT THAT MAY BE INCONSISTENT, THE FOLLOWING DEFINITIONS APPLY ONLY FOR PURPOSES OF EXPLAINING THE REQUIREMENTS OF THIS REPORT G.8. THE NUMBERED TERMS SET FORTH BELOW CORRESPOND WITH THE NUMBERS OR HEADINGS ON THE REPORT G.8.

**General:**

Report G.8 is one of the Quarterly Financial Reports and shall be submitted to DMAP in accordance with Section 3 of this Exhibit G. Contractor shall report in the column labeled OHP Contract Line the expenses associated with providing service to DMAP Members and shall report in the column labeled Corporate Activity the Contractor's total financial information of the for-profit or not-for-profit corporation which is not a foreign corporation, incorporated under or subject to the provisions of Chapter 60 and ORS 732.005 of the Oregon Insurance Code. If Contractor is not a corporation, Contractor shall report in the column labeled OHP Contract Line the expenses associated with providing service to DMAP Members and shall report in the column labeled Corporate Activity the Contractor's total financial information. Amounts appearing on Report G.8 shall equal the total reported annually on Report G.6.

Allocation of expenditures between OHP Line of Business and Corporate Line of Business: If separate accounts are not kept for the OHP, revenue, expenses and net worth information for the OHP shall be allocated using an estimation procedure approved by DMAP. Such a procedure and all assumptions must be disclosed in Notes to Report G.8. This estimation procedure must be used throughout the reports. The assumptions underlying the allocation must be based on a methodology that clearly represents the true costs associated with providing services to DMAP Members

**Contractor shall submit Details of Write-Ins** - Any item which is a component of any other line, is greater than 10% of the amount on the Subtotal Line (i.e. Line 7, 16 or 25), and whose value is greater than $1,000 will need to be described on these lines and the amount of the item disclosed. On the description line, please reference the line number of the Other Line (i.e. Line 5,6,15, 24, or 38e), identify the expense, and disclose the amount of the expense being claimed.

**Instructions:**

**(1)** **Premiums** - revenue recognized (net of reinsurance premium paid to the reinsurer on a prepaid basis from individuals and groups for provision of a specified range of health services over a defined period of time. Include DMAP Capitation and Maternity case rate payments and net of reinsurance premiums ceded. If advance payments are made to Contractor for more than one report period, the portion of the payment that has not yet been earned must be treated as a liability (unearned premiums).

**(2)** **Corporate Fee-For-Service** - revenue recognized by Contractor for provision of health services to non-DMAP Members by Contractor practitioners and to DMAP Members through provision of health services excluded from their prepaid benefit packages.

**(3)** **Corporate Title XIX-Other Medicaid** - other Medicaid revenues as a result of other non-capitated arrangements between Contractor and a Medicaid State Agency, for services to a Medicaid beneficiary.

**(4)** **Corporate Net Investment Income** - income earned from investments, deposits and reserve accounts, including net realized capital gains or losses.

**(5)** **Corporate Other Health Care Related Revenues** - revenue recognized for provision of health services over a defined period of time not included in previous revenue categories.

**(6)** **Non Healthcare-Related Revenues** - other revenues not included in the previous revenue categories.

**(7)** **TOTAL REVENUES** - the sum of Line 1 through Line 6.

**(8)** **Physician/Professional Services** - expenses for physician services provided under contractual arrangement to Contractor including physician salaries, fringe benefits, Capitated Payments paid to physicians, fees paid to physicians on a fee-for-service basis for delivery of medical services, including capitated referrals. Compensations, as well as fringe benefits, paid by Contractor to non-physician practitioners engaged in the delivery of medical services and to personnel engaged in activities in direct support of the provision of medical services. Include expenses for practitioners not under contractual arrangements with Contractor. Exclude expenses for medical personnel time devoted to administrative tasks.

Physician shall be defined to include practitioner who is an allopathic, osteopathic, homeopathic, podiatric, chiropractic, or naturopathic physician, physician assistant, and nurse practitioner.

Professionals include dentists, psychologists, optometrists, nurses, clinical personnel such as ambulance drivers, technicians, paraprofessionals, quality assurance analysts, administrative supervisors and medical record clerks.

**(9)** **Hospital Services:**

**(a)** **Inpatient** – Inpatient hospital costs for Contractor members while confined to an acute care hospital, including out of area hospitalization. Include the cost of skilled nursing and intermediate care facilities.

**(b)** **Outpatient** – Outpatient hospital costs for Contractor members not confined to an acute care hospital, including out of area Outpatient services.

**(c)** **Emergency Room** – expenses for emergency room services, including out of area emergency services.

**(10)** **Pharmacy** – retail pharmacy costs, net of rebates and administrative fees.

**(11)** **Lab and X-ray** – independent laboratory and x-ray services for Contractor members.

**(12)** **Vision** - non-medical/routine vision exams and related hardware.

**(13)** **Chemical Dependency** – services provided by alcohol or chemical dependency Providers.

**(14)** **Durable Medical Equipment & Supplies** - independent Providers of DME and Supplies. Equipment that can stand repeated use and is primarily and customarily used to serve a medical purpose and non-reusable medical supply items used in the treatment of illness or injury.

**(15)** **Other Medical and Hospital Expenses** - other expenses for medical and hospital services not included in the above categories, including IBNR costs.

**(16)** **MEDICAL AND HOSPITAL EXPENSES SUBTOTAL** - the sum of Line 8 through Line 15.

**(17)** **Reinsurance Recoveries Incurred** - reinsurance recovered from the reinsurer on paid losses and those amounts that have been billed to the reinsurer and not yet received. Include reinsurance recovered and recoverables on paid losses. Unpaid losses are netted against the appropriate medical and hospital expense lines 9 -16. NOTE: this is NOT a net figure.

**(18)** **Corporate Co-payments** - revenue recognized by Contractor from members on a utilization-related basis for certain health services included in the benefit package.

**(19)** **TPR, COB, and Subrogation** - income earned from Third Party Recoveries, coordination of benefits, and subrogation.

**(20)** **DEDUCTIONS SUBTOTAL** - the sum Lines 17 through 19.

**(21)** **TOTAL MEDICAL AND HOSPITAL EXPENSES LESS DEDUCTIONS** - the sum of Line 16 minus Line 20.

**(22)** **Compensation** - Include salaries and wages, bonuses and incentive compensation to employees, overtime payments, continuation of salary during temporary short-term absences, dismissal allowances, payments to employees while in training and other compensation to employees not specifically designated to another expense category. Include fees and other compensation to directors for attendance at board or committee meetings and any other fees and compensation paid to them in their capacities as directors or committee members. Report agency compensation other than commissions. Use allocation method described above.

**(23)** **Marketing/Educational Materials and advertising** - Expenses directly related to marketing activities. Include such items as 1) newspaper, magazine and trade journal advertising for the purpose of solicitation and conservation of business, 2) all calendars, blotters, wallets, advertising novelties, etc., for distribution to the public, 3) print, paper stock, etc. in connection with advertising, 4) prospect

and mailing lists when used for advertising purposes and 4) pamphlets on educational subjects or other member materials specifically relating to the OHP Line of Business. Omit salaries and expenses of advertising department personnel, help-wanted advertisements, and advertising in connection with investments. Use allocation method described above.

**(24)** **Other Administrative Expenses** – payment made for other administrative expenses associated with the overall management and operations of Contractor not included in the above categories. Use allocation method described above.

**(25)** **TOTAL ADMINISTRATIVE EXPENSE** - the sum of items of Line 22 through Line 24.

**(26)** **TOTAL EXPENSES** - the sum of Line 21 and Line 25.

**(27)** **INCOME (LOSS) (before taxes)** - the result of Line 7 minus Line 26.

**(28)** **MCO Tax** – the expense for MCO Tax.

**(29)** **Provision for Income Taxes** - the expense for income taxes for the report period.

**(30)** **NET INCOME (LOSS)** - the result of Line 27 minus Line 28 minus Line 29.

**(31)** **Corporate Net Worth Beginning of Quarter** - the total of common stock, preferred tock, paid in surplus, contributed capital, surplus notes, contingency reserves, retained earnings/fund balance, and other items at the beginning of the report period.

**(32)** **Increase (Decrease) in Common Stock** - the change in the net worth of common stock from the last report period to the current report period.

**(33)** **Increase (Decrease) in Preferred Stock** - the change in the net worth of preferred stock from the last report period to the current report period.

**(34)** **Increase (Decrease) in Paid in Surplus** - the change in the net worth of paid in surplus from the last report period to the current report period.

**(35)** **Increase (Decrease) in Contributed Capital** - the change in the net worth of contributed capital from the last report period to the current report period.

**(36)** **Increase (Decrease) in Surplus Notes** - the change in the net worth of surplus notes from the last report period to the current report period.

**(37)** **Increase (Decrease) in Contingency Reserves** - the change in the net worth of contingency reserves from the last report period to the current report period.

**(38) Increase (Decrease) in Retained Earnings/ Net Worth** - the change in the net worth of retained earnings/net worth from the last report period to the current report period.

**(39) Corporate Net Worth at End of Quarter** - the total of common stock, preferred stock, paid in surplus, contributed capital, surplus notes, contingency reserves, retained earnings/fund balance, and other items at the end of the report period.

**i. Report G.9: Quarterly Financial Reporting – Cash Flow Analysis for Corporate Activity:**

NOTWITHSTANDING ANY DEFINITIONS IN THIS CONTRACT THAT MAY BE INCONSISTENT, THE FOLLOWING DEFINITIONS APPLY ONLY FOR PURPOSES OF EXPLAINING THE REQUIREMENTS OF THIS REPORT G.9. THE NUMBERED TERMS SET FORTH BELOW CORRESPOND WITH THE NUMBERS OR HEADINGS ON THE REPORT G.9.

**General:**

Report G.9 is one of the Quarterly Financial Reports and shall be submitted to DMAP in accordance with Section 3 of this Exhibit G. The Statement of Cash Flow shall be prepared using the Direct Method of reporting cash flow. Cash from operations shall be reported consistent with the Statement of Income, excluding the effect of current and prior year accruals. Only the cash portion of a transaction shall be reported in the Statement of Cash Flow.

**Instructions:**

**Corporate Activity** - the financial position of a for-profit or not-for-profit corporation, which is not a foreign corporation, incorporated under or subject to the provisions of Chapter 60, ORS and ORS 732.005 relating to activities that the corporation performs. Includes the OHP line of business. Any PHP not a corporation should regard its total PHP business as corporate activity.

**CASH FLOWS PROVIDED BY OPERATING ACTIVITIES** - financial report estimating cash generated or lost from operating activities for both not-for-profit as well as for-profit corporations.

**(1) Net Income (Loss)** report Corporate Activity of Report G.8, Line 30 for the current quarter.

**(2) Depreciation and Amortization** - report back items not requiring the use of cash, such as depreciation.

**(3) Premium Receivable** - report any cash flow generated or lost by changes in premium receivables. Include non-cash or non-cash equivalent transactions. Remove the effects of all deferrals of receipts and payments and accruals of receipts and payments.

**(4)** **Due from Affiliates** - report any cash flow generated or lost by changes in amounts due to affiliates. Include non-cash or non-cash equivalent transactions. Remove the effects of all deferrals of receipts and payments and accruals of receipts and payments.

**(5)** **Health Care Receivable** - report any cash flow generated or lost by changes in health care receivables. Include non-cash or non-cash equivalent transactions. Remove the effects of all deferrals of receipts and payments and accruals of receipts and payments.

**(6)** **Other (Increase) Decrease in Operating Assets** - report any cash flow generated or lost by changes in other operating assets. Include non-cash or non-cash equivalent transactions. Remove the effects of all deferrals of receipts and payments and accruals of receipts and payments.

**(7)** **Accounts Payable** - report any cash flow generated or lost by changes in accounts payable. Include non-cash or non-cash equivalent transactions. Remove the effects of all deferrals of receipts and payments and accruals of receipts and payments.

**(8)** **Claims Payable** - report any cash flow generated or lost by changes in medical Claims payable. Include non-cash or non-cash equivalent transactions. Remove the effects of all deferrals of receipts and payments and accruals of receipts and payments.

**(9)** **Accrued Medical Incentive Pool** - report any cash flow generated or lost by changes in accrued medical incentive pool. Include non-cash or non-cash equivalent transactions. Remove the effects of all deferrals of receipts and payments and accruals of receipts and payments.

**(10)** **Unearned Premiums** - report any cash flow generated or lost by changes in unearned premiums. Include non-cash or non-cash equivalent transactions. Remove the effects of all deferrals of receipts and payments and accruals of receipts and payments.

**(11)** **Due to Affiliates** - report any cash flow generated or lost by changes in amounts due to affiliates. Include non-cash or non-cash equivalent transactions. Remove the effects of all deferrals of receipts and payments and accruals of receipts and payments.

**(12)** **Other Increase (Decrease) from Operating Activities** - report any other cash flow generated or lost by changes in other operating liabilities. Include non-cash or non-cash equivalent transactions. Remove the effects of all deferrals of receipts and payments and accruals of receipts and payments.

**(13)** **NET CASH PROVIDED (USED) FROM OPERATING ACTIVITIES** - sum of Line 1 through Line 12. To arrive at net cash provided by operating activities, remove from net income the effects of all deferrals of receipts and payments and accruals of receipts and payments.

**(14)** **Receipts from Investments** - cash generated by the transfer of cash out of either short-term or long-term investment transactions, including restricted cash reserves and other assets that relate to transactions reported in Report G.7.

**(15)** **Receipts for Sales of Property and Equipment** - cash generated by the transfer of cash into property and equipment sales transactions reported in Report G.7. Include any advance payments, down payments or other payments made at the time of purchase or shortly before or after the purchase of the property and equipment and productive assets including leasehold improvements.

**(16)** **Payments for Investments** - cash lost by the transfer of cash into either short-term or long-term investment transactions reported in Report G.7. Include cash lost by transfer of cash into restricted cash reserves and other assets that relate to transactions reported in Report G.7.

**(17)** **Payments for Property and Equipment** - cash lost by the transfer of cash into property and equipment sales transactions reported in Report G.7. Include advance payments, down payments, or other amounts paid at the time of purchase or shortly before or after the purchase of the property and equipment.

**(18)** **Other Increase (Decrease) in Cash Flow for Investing Activities** - report any other cash flow generated or lost by changes in investing activities.

**(19)** **NET CASH PROVIDED BY INVESTING ACTIVITIES** - sum of Lines 14 through 18.

**(20)** **Proceeds from Paid in Capital or Issuance of Stock** - cash generated by the transfer of cash from paid in capital surplus or issuance of stock.

**(21)** **Loan Proceeds from Non-Affiliates** - cash generated by the transfer of cash from loan proceeds transactions from non-affiliates.

**(22)** **Loan Proceeds from Affiliates** - cash generated by the transfer of cash from loan proceeds transactions from affiliates. Include loan and notes payable transactions reported in Report G.7. Exclude interest.

**(23)** **Principal Payments on Loans from Non-Affiliates** - cash lost by the transfer of cash from loan proceeds transactions from non-affiliates.

**(24)** **Principal Payments on Loans from Affiliates** - cash lost by the transfer of cash from loan proceeds transactions from affiliates. Include loan and notes payable transactions reported in Report G.7.

**(25)** **Dividends Paid** - cash lost by paying dividends reported in Report G.8.

**(26)** **Principal Payments under Lease Obligations** - cash lost by the transfer of cash from loan proceeds transactions from lease obligations. Include loan and notes payable transactions reported in Report G.7.

**(27) Other Cash Flow Provided by Financing Activities** - any cash flow generated or lost by the transfer of cash in a financial transaction.

**(28) NET CASH PROVIDED BY FINANCING ACTIVITIES** - sum of Line 20 through Line 27.

**(29) NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS** - the sum of Line 13, Line 19 and Line 28.

**(30) CASH AND CASH EQUIVALENTS AT BEGINNING OF REPORT PERIOD** - the total net cash provided by operating activities, by investing activities, and by financing activities at the beginning date specified in the report period on Report G.7.

**(31) CASH AND CASH EQUIVALENTS AT END OF REPORT PERIOD** - the sum of Line 29 and Line 30.

**j. Report G.10: Corporate Relationships of Contractors:**

NOTWITHSTANDING ANY DEFINITIONS IN THIS CONTRACT THAT MAY BE INCONSISTENT, THE FOLLOWING DEFINITIONS APPLY ONLY FOR PURPOSES OF EXPLAINING THE REQUIREMENTS OF THIS REPORT G.10. THE NUMBERED TERMS SET FORTH BELOW CORRESPOND WITH THE NUMBERS OR HEADINGS ON THE REPORT G.10, SECTIONS (A), (B) AND (C).

**General:**

Report G.10 Part I, Part II, and Part IV are part of the Quarterly Financial Reports and shall be submitted to DMAP in accordance with Section 3 of this Exhibit G. Report G.10 Part III is an annual requirement, and shall be submitted with the 4th quarter report.

**Instructions:**

**Part I.** Corporate Relationship and Organizational Structure:

**Organizational chart** - submit on August 31st of each year(s) Contract is in effect.

**Part II.** Summary of Risk-Sharing Transactions with Provider Groups:

**Health Care Delivery Systems** - an organized method of providing health care services such as Independent Provider Association (IPA) as a group, Primary Care Practitioners (PCP) as individuals or groups, etc.

**Line 1** Independent Provider Association (IPA) - a type of health care delivery system consisting of an IPA or group with which Contractor negotiates price discounts in exchange for the Providers affiliated with that IPA or group having guaranteed access to enrolled DMAP Members.

**Line 2** Primary Care Practitioners (PCP) - a type of health care delivery system consisting of either an individual practitioner or a group of Affiliated Primary Care Practitioners with which Contractor negotiates price discounts in exchange for the affiliated Providers having guaranteed access to enrolled DMAP Members.

**Affiliated Primary Care Practitioners** - Physicians, Nurse Practitioners, and Physician Assistants whose practice type is Family Practice, General Practice, Internal Medicine, Pediatrics, or Obstetrics/Gynecology.

**Line 3 Specialist Practitioners** - a type of health care delivery system consisting of either an individual practitioner or a group of affiliated specialist practitioners with whom Contractor negotiates price discounts in exchange for the affiliated Providers having guaranteed access to enrolled DMAP Members.

**Affiliated Specialist Practitioners** - Physicians other than a PCP. Under most circumstances, these services would be performed by Providers to whom the DMAP Member has been referred by his or her PCP. Ancillary services (defined in OAR 410-141-0480) should not be included here.

**Line 4** Lab/X-ray Service Providers, Individual or Group - a type of health care delivery system consisting of individual or a group of affiliated laboratory or x-ray Providers with which Contractor negotiates price discounts in exchange for the affiliated Providers having guaranteed access to enrolled DMAP Members.

**Line 5** Hospital Providers, Individual or Group - a type of health care delivery system consisting of individual or a group of affiliated hospital Providers with which Contractor negotiates price discounts in exchange for the affiliated Providers having guaranteed access to enrolled DMAP Members.

**Line 6** Other Inpatient Providers - a type of health care delivery system consisting of individual or a group of affiliated Other Inpatient Providers with which Contractor negotiates price discounts in exchange for the affiliated Providers having guaranteed access to enrolled DMAP Members, such as an Independent Rehabilitation Contractor.

**Line 7** Other Providers, Individual or Group - a type of health care delivery system consisting of a group of affiliated Other Providers organized and affiliated Providers with which Contractor negotiates price discounts in exchange for the affiliated Providers having guaranteed access to enrolled DMAP Members, such as an Independent Home Health Agency or Durable Medical Equipment Contractor.

**Columns 1 through 9** - Service Payment Arrangements - arrangements developed between Contractor and Providers that determine the billed amount for health care services performed for DMAP Members enrolled with Contractor.

**Column 1** Salary Payments - arrangements developed between Contractor and Providers where Providers receive a salary from Contractor in exchange for the provision of health care services for DMAP Members enrolled with Contractor.

**Column 2** Fee-For-Service Payments - arrangements developed between Contractor and Providers where Providers receive a payment from Contractor in exchange for the provision of health care services for DMAP Members enrolled with Contractor, dependent on the actual number and nature of services provided to each DMAP Member.

**Columns 3 through 7** - Capitation Payments - arrangements developed between Contractor and affiliated Providers who contract directly with Contractor, where Providers receive a fixed amount from Contractor in exchange for the provision of health care services for DMAP Members enrolled with Contractor, regardless of the actual number or nature of services provided to each DMAP Member.

**Column 3** To Primary Care Providers - total Capitation Payments derived from DMAP premiums made by Contractor to Primary Care Providers in a specific delivery system.

**Column 4** To Specialist Providers - total Capitation Payment derived from DMAP premiums made by Contractor to Specialist Providers in a specific delivery system.

**Column 5** To Lab/X-ray Service Providers - total Capitation Payment derived from DMAP premiums made by Contractor to Laboratory or Radiology Service Providers in a specific delivery system.

**Column 6** To Hospital Providers - total Capitation Payment derived from DMAP premiums made by Contractor to Hospital Providers in a specific delivery system.

**Column 7** To Other Providers - total Capitation Payment derived from DMAP premiums made by Contractor to other Providers types of health care delivery systems not included in table.

**Column 8** Payments to Non-Affiliated Providers - arrangements developed between Contractor and Providers not contracted with Contractors.

**Column 9** Stop-Loss Protection Payments - payments derived from DMAP premiums made by Contractor to specific delivery systems to provide monies used to cover future stop-loss protection expenses for those specific delivery systems.

**Part III Incentive Arrangements:**

**Columns 1 through 3** - Total Dollar Amount - total dollars to be returned to all Providers providing services to Contractor's enrolled DMAP Members as specified in the incentive arrangement.

**Columns 1 through 6** - Incentive Arrangements - arrangements between Contractor and Providers in a health care delivery system to provide an incentive for that system to take on additional financial responsibility in covering probable, future expenses incurred from providing health care services to Contractor's enrolled DMAP Members.

**Column 1** Provider Bonuses - an incentive arrangement where a certain amount is paid to Providers within the health care delivery system at a given point in time, in addition to the negotiated usual and customary payment arrangement on the basis of certain performance criteria.

**Column 2** Capitation Withhold - an incentive arrangement where a certain amount is removed from the negotiated Capitation Payment and set aside to be paid to the Providers within the health care delivery system at a given point in time on the basis of certain performance criteria.

**Column 3** Fee-For-Service Withhold - an incentive arrangement where a certain percentage of the usual and customary fee is removed from the base amount of the usual and customary fee and set aside to be paid to the Providers within the health care delivery system on the basis of certain performance criteria.

**Column 4** Total Across Delivery System - sum of (Columns 1, 2 and 3)

**Column 5** Multiple Risk Pools - an incentive arrangement where a certain amount is removed from the negotiated Capitation Payment of Providers within the health care delivery system and is set aside to be paid to all participating Providers at a given point in time on the basis of certain performance criteria.

**Column 6** Group/Individual Based Risk Pools - an incentive arrangement where a certain amount is removed from the negotiated Capitation Payment from individual Providers or organized groups of Providers within the health care delivery system and set aside to be paid to all participating Providers at a given point in time on the basis of certain performance criteria.

**Column 7** Name of Provider Responsible for Deficits in Excess of Withhold - the Provider within the health care delivery system determined through the incentive arrangement process to be responsible for any deficits that may be incurred in excess of withhold in the event that the total withhold is less than the expenses of the Providers participating in the withhold pool.

## Part IV. Intermediary Arrangements:

### General:

Contractor shall complete this Section if the Contractor pays 16% or more of its total administrative expenses to an individual intermediary or more than 25% of the DMAP premium revenue in a month to any individual intermediary to provide medical/hospital/dental services. If Contractor meets this standard, detail the administrative and medical/hospital/dental expenses paid by the Contractor to Intermediaries to perform the duties associated with the OHP Line of Business only.

### Instructions:

**(1)** **Total Salary and Wages/Compensation** - Include salaries and wages, bonuses and incentive compensation to employees, overtime payments, continuation of salary during temporary short-term absences, dismissal allowances, payments to employees while in training and other compensation to employees not specifically designated to another expense category. Include fees and other compensation to directors for attendance at board or committee meetings and any other fees and compensation paid to them in their capacities as directors or committee members. Report agency compensation other than commissions. - Include the wages and salaries of employees who are employed in the review of utilization such as Medical Director, ENCC staff, utilization review staff, etc. Include the wages and salaries of employees who are employed in the certification and accreditation of Providers.

**(2)** **External Utilization Management Fees** - Include management fees paid for utilization review services performed by Subcontractors.

**(3)** **External Certifications and accreditation Fees** - Include fees paid to organizations for certifications and accreditation of Providers.

**(4)** **External Legal fee and expenses** - Expenses directly related to legal activities and lobbying efforts.

**(5)** **External Auditing, actuarial and other consulting services expenses** - Exclude fees for examinations made by DCBS and expenses of internal audits by company employees.

**(6)** **Marketing and advertising** - Expenses directly related to marketing activities. Include such items as 1) newspaper, magazine and trade journal advertising for the purpose of solicitation and conservation of business, 2) all calendars, blotters, wallets, advertising novelties, etc., for distribution to the public, 3) print, paper stock, etc. in connection with advertising, 4) prospect and mailing lists when used for advertising purposes and 4) pamphlets on educational subjects or other member

materials specifically relating to the OHP Line of Business. Omit salaries and expenses of advertising department personnel, help-wanted advertisements, and advertising in connection with investments.

**(7)** **Claims processing -** Include payments to other entities for medical/hospital/dental Claims processing. Include management fees associated with administration of Claims processing systems. Do not include payments to intermediaries that would be distributed by those intermediaries for service payments. Include payments to other entities for pharmacy Claims processing. Include management fees associated with administration of Claims processing systems. Do not include payments to intermediaries that would be distributed by those intermediaries for service payments.

**(8)** **Reimbursements from intermediaries** - Payment to the Contractor from the intermediaries based on performance standards.

**(9)** **Reimbursements to intermediaries** - Payments to intermediaries from the Contractor based on performance standards.

**(10)** **Other administrative expenses** - Other administrative expenses not described in the lines above that are associated with the overall management and operation of Contractor.

**(11)** **Total administrative expenses** - Sum of Lines 4 through Line 10.

**12. through 20.** - Please refer to the definitions found on Report G.8, Line 9 through Line 20.

**(21)** **Total Medical/Hospital/Dental Expenses** - Sum of Lines 12 through Line 20.

**k. Report G.11: Incurred But Not Reported:**

NOTWITHSTANDING ANY DEFINITIONS IN THIS CONTRACT THAT MAY BE INCONSISTENT, THE FOLLOWING DEFINITIONS APPLY ONLY FOR PURPOSES OF EXPLAINING THE REQUIREMENTS OF THIS REPORT G.11. THE NUMBERED TERMS SET FORTH BELOW CORRESPOND WITH THE NUMBERS OR HEADINGS ON THE REPORT G.11.

**General:**

Report G.11 is one of the Quarterly Financial Reports and shall be submitted to DMAP in accordance with Section 3 of this Exhibit G. Contractors shall submit to DMAP the claims lag form for the Corporate Line of Business.

**Instructions:**

**Part 1.** Show the payment activity for each month, indicating on each line a paid month, the dollar amount of Claims paid in the incurred month, the dollar amount of Claims paid one, two, three, four, five or six months after incurred, and the total dollar amount of Claims paid. Please note that the months are in descending order

**Part 2.** Fill out the cumulative percentage of paid claims lag form below for the corporate line of business, showing the cumulative paid claims as a percentage of current estimated incurred based on Claims paid and incurred provided in the previous table (1.). Please note the months are in descending order.

**l. Report G.12: Instructions for Filing the Physician Incentive Plan Disclosure Form:**

NOTWITHSTANDING ANY DEFINITIONS IN THIS CONTRACT THAT MAY BE INCONSISTENT, THE FOLLOWING DEFINITIONS APPLY ONLY FOR PURPOSES OF EXPLAINING THE REQUIREMENTS OF THIS REPORT G.12. THE NUMBERED TERMS SET FORTH BELOW CORRESPOND WITH THE NUMBERS OR HEADINGS ON THE REPORT G.12.

**General:**

Contractor shall submit to DMAP a Physician Incentive Plan (PIP) Disclosure Form, on August 31st of each year that this Contract is in effect, to comply with the requirements of 42 CFR 422.208-422.210. Contractors may submit to DMAP either the Physician Incentive Plan Disclosure Form within this Exhibit G or CMS's PIP Disclosure Form (OMB No. 0938-0700), except in the case of Contractor who is regulated by DCBS, who will submit the same information to be provided to CMS. Contractor shall provide DMAP with additional information upon request. Contractor shall submit this report either electronically or by mail. Forms, worksheets and instructions to assist Contractors in preparing the Physician Incentive Plan Disclosure Form can be obtained by accessing the CMS web site: http://www.cms.hhs.gov/manuals/downloads/mc86c06.pdf. Contractors shall disclose physician incentive arrangements for Providers within the Contractor's network on an annual basis. A PIP disclosure shall include:

**(1)** The disclosure Cover Sheet - this sheet should be the first page of the PIP submission.

**(2)** PIP Disclosure Form - This form may be duplicated as necessary to capture all of the arrangements in effect amongst the applicant's Provider contractors and Subcontractors down to the level of physicians.

The PIP Worksheet may be used as a guide in determining if there is substantial financial risk in any Provider arrangement and to assist the Contractors in entering data on the disclosure form. Contractors may modify the CMS Worksheet for their internal use as long as the necessary information is captured that will document the data. Generally, a separate Worksheet should be used for each type of contractual

relationship. Reproduce as many of these forms as needed. Do not submit the Worksheets, but retain them and any other supporting information for review by DMAP or CMS. Contractors should analyze the data from different Providers to determine whether information from the same type of contracting entity can be aggregated for disclosure to DMAP. Contractors need to determine if they have received all information from their contractors down to the level of physicians, even if the Providers bear no risk or there is no substantial financial risk.

**(1)** An intermediate entity should report its direct contracts with physicians as well as arrangements with its physician groups and the physician groups' physicians. Even if there is no substantial financial risk in any contractual arrangement, the lower levels must be disclosed.

**(2)** A physician group should report arrangements with its physicians, even if there is no substantial financial risk between the Contractor and the physician group.

Nine contractual relationships are listed. Disclose one type of relationship on each Form you complete. Submit as many Forms as you need to represent all of the arrangements that serve the Contractors Medicaid enrollees.

**(1)** Contractor to physician group

**(2)** Contractor to intermediate entity

**(3)** Contractor to individual physician

**(4)** Intermediate entity to physician group

**(5)** Intermediate entity to physician

**(6)** Physician group to physician group

**(7)** Physician group to physician

**(8)** Physician to physician

**(9)** Intermediate entity to intermediate entity.

Each submission from a Contractor must include contractual relationships (1), (2) or (3), but Contractors may have multiple arrangements and need all three. The Contractor must disclose the subcontracting arrangements to the level of the physician. All disclosures relating to one hierarchy of contracts should be stapled together. The hierarchies are:

**Selection of:** **(1)** Contractor to physician group requires a disclosure of:
(7) Physician group to physician OR
(6) Physician group to physician group.

If (6) is selected, you must have (7) to disclose incentives to physicians. There can be selection of: (8) Physician to physician [this is not required].

**Selection of:** **(2)** Contractor to intermediate entity requires disclosure of:
(4) Intermediate entity to physician group OR
(5) Intermediate entity to physician OR
(9) Intermediate entity to intermediate entity. The intermediate entity can have multiple contracting arrangements.
If (4) is selected, you must have (7) to disclose incentives to physicians
If (9) is selected, you must have (4) or (5) to disclose incentives to Subcontractors. There can be selection of: (8) Physician to physician [this is not required].

**Selection of:** **(3)** Contractor to individual physician does not require any subcontract. There can be selection of: (8) Physician to physician [this is not required].

Single or aggregate disclosure: The Disclosure Form may reflect a single incentive arrangement if that is a unique arrangement. However, Contractors should aggregate information on one form for contractual arrangements that are substantially the same and the stop-loss requirements are the same. For example, if a Contractor contracts with 100 physician groups under a very similar Capitation Payment that does not pass referral risk to the groups, the Contractor should check category 1 on the Disclosure Form and disclose all 100 on one Form. If 55 physician groups do not pass risk to their doctors and these 55 groups have a total of 450 physicians under this no risk compensation, then the Contractor should check category 7 on a new Disclosure Form and disclose all 450 on the Form. Similarly, the Contractor should disclose the physician group-physician incentive arrangements for the other 45 groups, aggregating those physicians who are placed at substantially the same risk and who have the same stop loss requirements, if the risk exceeds the SFR cutoff. Staple together all the forms that relate to the 100 physician groups.

**Instructions:**

**Line 1.A.** Give the name or identifier of a single Provider (e.g., the intermediate entity, physician group, or individual physician) or the Providers who are aggregated for the disclosure. The Provider named or identified is the party who receives payment under the Provider contract to which the Disclosure Form applies. The purpose here is to allow the user to be able to identify the Provider(s) after entering the data.

**Line 1.B.** Give the number of aggregated Providers whose arrangements are being disclosed. (See the discussion above.) Do not send lists of Provider names. For example, if #1 is selected, then give the number of physician groups.

**Line 1.C.** Asks for disclosure of Federally Qualified Health Centers and Rural Health Clinics (FQHC/RHCs). Please distinguish FQHC/RHCs by using a separate Disclosure Form to report each FQHC/RHC, however you may aggregate those with

substantially the same incentive arrangements. If the MCO is owned or controlled by a consortium of FQHC/RHCs or has FQHC/RHCs in its network, be sure to indicate this on the cover sheet.

**Line 1.D.** Applies only to physicians of physician groups (selection of #7 contracting type) and asks for a breakout of the number of physicians who are members of the group and those who independently contract with the group. Members are typically owners, partners, or employees of the physician group.

If either arrangement with Providers that are intermediate entities (IE) is selected on the Disclosure Form (either #2 or #9), complete items 1.A - 1.C only since stop loss requirements do not apply to intermediate entities (IE). However, fully complete disclosures for IE's relationships with Provider groups and their physicians (#4 and #7) and IE with individual physicians (#5) because stop loss requirements apply to these levels.

**Question 2** Identifies whether the incentive arrangement transfers any risk. A Capitation Payment is considered a transfer of risk for this question, even if the capitation is for services provided only by the contracting physician or physician group. [This information is found in the Worksheet.]

Check "yes" or "no", as applicable. If "no" is checked, then this disclosure is complete. If "yes" is checked, identify the type of risk transfer; then go to Question 3.

Risk transfer choices are: "capitation, bonus, withhold, percent of premium or other." Check the appropriate choice or choices; more than one choice should be checked if the arrangement has features of each type of risk-sharing.

A choice of "Other" is provided if a combination of the four types of risk arrangement does not define the arrangement. For the purpose of this Disclosure Form, the obligation for the Provider to fund deficits is considered as a "withhold." A bonus for low utilization of referral services is considered to be risk transference.

**Question 3** Identifies whether risk is transferred for referrals. [This information is in the Worksheet.] Check "yes" or "no", as applicable. A bonus for low utilization of hospital, specialist or other services is considered to be a risk for referral services. If "no" is checked, then this disclosure is complete. If "yes" is checked, go to Question 4 to identify the type of risk transfer.

**Question 4** Identifies the type of risk-sharing arrangement. [This information is found in the Worksheet.] See #2 above for instructions on identifying risk arrangements.

The risk-sharing arrangement may be described briefly on the Disclosure Form, particularly if 'other' is selected.

**Question 5** The percentage of risk attributable to referrals only should be stated in Question 5. This percentage corresponds to the "% Of Total Compensation At Risk For Referrals" from the Worksheet. If the percentage is equal to or below 25 %, the

arrangement is not considered to be at substantial financial risk and this disclosure is complete. Percent of premium is treated as capitation for this calculation. If above 25 percent, proceed to Question 6.

**Question 6** Information for Question 6, about the number of patients, is found in the Worksheet. Specific criteria must be met before pooling is allowed, as stated in regulations. Any entity that meets all five criteria (below) required for the pooling of risk will be allowed to pool that risk in order to determine the amount of stop-loss required by the regulation. If the number of patients is 25,000 or fewer, then go to Question 7. If greater than 25,000, the disclosure is complete.

**(1)** Pooling of patients is otherwise consistent with the relevant contracts governing the compensation arrangements for the physician or group (i.e., no contracts can require risk be segmented by Contractor or patient category);

**(2)** The physician or group is at risk for referral services with respect to each of the categories of patients being pooled;

**(3)** The terms of the compensation arrangements permit the physician or group to spread the risk across the categories of patients being pooled (i.e., payments must be held in a common risk pool);

**(4)** The distribution of payments to physicians from the risk pool is not calculated separately by patient category (either by Contractor or by Medicaid, Medicare, or commercial); and

**(5)** The terms of the risk borne by the physician or group are comparable for all categories of patients being pooled.

Note that pooling and stop-loss requirements applicable to a group cannot be extended to a subcontracting level. For example:

A physician group has greater than 25,000 patients that meet pooling criteria. This group contracts with another physician group, which has 25,000 or fewer patients and bears risk for referrals above 25%.

The first group is exempt from stop-loss requirements; the second group must comply with stop-loss requirements and the Contractor must comply with survey requirements.

**Question 7** Note the type and the levels or thresholds of the stop-loss insurance if stop-loss coverage for the physician group or physician is required.

Check the type of stop-loss, aggregate, individual per patient, or other coverage. * If individual, give the threshold (deductible) as a dollar amount. If aggregate or other, briefly describe the stop-loss coverage. If there are arrangements that merit explanation, describe the coverage (if needed, attach a sheet for additional space).

A description should include whether the coverage is:

**(1)** Combined (professional and institutional);

**(2)** Broken down into institutional, professional and other components;

**(3)** The deductible, co-insurance percentage, maximum liability/pay-out by the policy;

**(4)** Whether the stop-loss coverage applies to all costs or only the cost of referral services; and

**(5)** Any other key features of the coverage.

This information is found in the Worksheet.

If Providers can be aggregated because of the similarity of risk arrangements, the Contractor should sort the Providers by stop loss requirements and then use a separate Disclosure Form for each requirement. For example: 100 groups exceed the 25% risk threshold; 50 have a patient pool exceeding 25,000 (under a very similar risk arrangement); 25 have a patient pool of between 1,001 and 5,000 (under a very similar risk arrangement); and another 25 of these groups have a patient pool of between 8,001 and 10,000. The Contractor should use three Disclosure Forms to represent the groups that aggregate into three stop loss requirements.

## EXHIBIT G – Attachment 1 Form G.1

Report Period: _____through _____

**GENERAL INFORMATION AND CERTIFICATION**

**I. General Information**

**A.** Contractor _____

**B.** Address _____

_____

**C.** Prepared by _____

**D.** Phone Number _____

**E.** Email Address _____

**II. Certification is to be signed by an official of the company and the original is to be mailed to DMAP.**

I, the undersigned, hereby attest that I have authority to certify the data and information and I, the undersigned, hereby certify based on best knowledge, information, and belief that the data and information is accurate, complete and truthful.

Signed _____

Title _____

Date _____

***REPORT FORMS G.1 THROUGH G.12 AND FORM G.1 ARE REPLICATIONS OF ELECTRONIC FILES.**

# EXHIBIT G – Attachment 2 - Report G.1 – Restricted Reserves

**I.Contractor**:

Report

Report Period:

**II. Restricted Reserves Level - Computation:**

| | Obligation | Held |
|---|---|---|
| Primary Res. | 250,000 | |
| Secondary Res. | | |
| Total | | |

**III.** Report G1 is one of the Quarterly Financial Reports and shall be submitted to OMAP in accordance with Section C of this Exhibit G. Contractor shall elect by checking one of the following methods for purposes of calculating Average Fee-For-Service Liability:

_____ No documentation required. Annually on August 31, Contractor shall provide their unique Certification of Authority number issued by DCBS and provide documentation showing the type and amount of additional assets required by DCBS.

_____ Based on Historical Expense Data. Contractor elects to use Historical Expense Data derived from Report G8 and G10 for purposes of determining Average-Fee-For-Service Liability. Contractor shall attach a current statement showing the level of funds held in reserves.

_____ Based on Enrollment Data. Contractor elects to use Enrollment Data for purposes of calculating the Average-Fee-For-Service Liability. Contractor shall complete Part II of this Report G1 to determine their Average-Fee-For-Service Liability. Contractor shall attach a current statement showing the level of funds held in reserves.

**IV.** Provide the following data to determine the average monthly fee-for-service liability for capitated services:

| Month in Quarter | Eligibility Category | Capitation Rate | Monthly Enrollees | Medical Loss Ratio | Ave Monthly Fee-For Service Liability for Capitated Services |
|---|---|---|---|---|---|
| 1st Month | OHP - Families | | | | |
| | PLM Adults under 100% FPL | | | | |
| | PLM Adults from 100% up to 185% FPL | | | | |
| | PLM, CHIP, or TANF Children, 0-1 years | | | | |
| | PLM, CHIP, 0r TANF Children, 1-5 years | | | | |
| | PLM, CHIP, or TANF Children, 6-18 years | | | | |
| | AB/AD without Medicare Eligibles | | | | |
| | AB/AD with Medicare Eligibles | | | | |
| | OAA without Medicare Eligibles | | | | |
| | OAA with Medicare Eligibles | | | | |
| | OHP - Adults & Couples | | | | |
| | SCF Children | | | | |
| | TANF Adults | | | | |
| | Maternity | | | | |
| 2nd Month | OHP - Families | | | | |
| | PLM Adults under 100% FPL | | | | |
| | PLM Adults from 100% up to 185% FPL | | | | |
| | PLM, CHIP, or TANF Children, 0-1 years | | | | |
| | PLM, CHIP, 0r TANF Children, 1-5 years | | | | |
| | PLM, CHIP, or TANF Children, 6-18 years | | | | |
| | AB/AD without Medicare Eligibles | | | | |

| | | | | | |
|---|---|---|---|---|---|
| | AB/AD with Medicare Eligibles | | | | |
| | OAA without Medicare Eligibles | | | | |
| | OAA with Medicare Eligibles | | | | |
| | OHP - Adults & Couples | | | | |
| | SCF Children | | | | |
| | TANF Adults | | | | |
| | Maternity | | | | |
| 3rd Month | OHP - Families | | | | |
| | PLM Adults under 100% FPL | | | | |
| | PLM ADULTS from 100% up to 185% FPL | | | | |
| | PLM, CHIP, or TANF Children, 0-1 years | | | | |
| | PLM, CHIP, 0r TANF Children, 1-5 years | | | | |
| | PLM, CHIP, or TANF Children, 6-18 years | | | | |
| | AB/AD without Medicare Eligibles | | | | |
| | AB/AD with Medicare Eligibles | | | | |
| | OAA without Medicare Eligibles | | | | |
| | OAA with Medicare Eligibles | | | | |
| | OHP - Adults & Couples | | | | |
| | SCF Children | | | | |
| | TANF Adults | | | | |
| | Maternity | | | | |
| Average across three months | | | | | |

## EXHIBIT G – Attachment 3 - Report G.2 – DMAP Member Approaching or Surpassing Stop-Loss Deductible

**I.** Contractor_____

Report Period:_____ through _____

**General** - This information is used by DMAP to assess the catastrophic stop-loss exposure of each Contractor.

**II.** Provide the following information about the number of DMAP Members whose costs on approved health care Claims are within the range of catastrophic stop-loss deductible for the calendar quarter. All Contractors shall complete Part 1 and submit to DMAP, quarterly.

| Plan Health Care Claims: | Medical Stop-Loss Claims | Hospital Stop-Loss Claims | Aggregate Stop-Loss Claims |
|---|---|---|---|
| 1. Number of DMAP Members with Claims Greater than $100,000 | | | |
| 2. Number of DMAP Members with Claims Greater than Reinsurance Cap. | | | |

**III.** Provide the following information about reinsurance. Provide one report for each reinsurer. All Contractors shall provide the following, annually, unless there is a change then Contractors shall submit within 15 days of the date of the change.

**A.** What is the amount of the stop-loss thresholds (i.e. the deductible amounts) and the associated type of stop-loss coverage (hospital, professional or aggregate coverage)?

Professional:
Hospital:
Aggregate:

**B.** What is the dollar amount of a Claim or the percentage of the total Claim amount whereby the responsibility for covering the Claim reverts back to the Contractor from the reinsurer?

**C.** What is the stop-loss fiscal year of reinsurance coverage?

**D.** Who is the carrier?

**E.** Is this carrier authorized in Oregon?

## EXHIBIT G – Attachment 4 - Report G.3 – Oregon Health Plan Key Utilization Indicators

Rescinded October 1, 2001

# EXHIBIT G – Attachment 5 - Report G.4 – OHP Access to Services Statistics

**I.** Contractor_____

Report Period:_____ through _____

## II. Usage of Services

Please indicate the usage of services by members for which Claims were incurred in the prior report quarter and the number of members for which no Claims were incurred in the prior quarter as of the end of the current report quarter. Use date of service reflecting the prior quarter's report period to compile the data. Use the unduplicated number of members enrolled during the quarter to determine the number of members not receiving services.

| | Number |
|---|---|
| 1. Number of unduplicated Members Enrolled during the Prior quarter with Paid Claims. | |
| 2. Number of unduplicated Members Enrolled during the Prior Quarter with No Paid Claims. | |
| 3. Total number of unduplicated Members Enrolled in Prior Quarter. (Prior Quarter Report: Part III(B) , Line 3) | 0 |

## III. Membership

**A.** For those entities that are regulated by DCBS, provide general membership information for your corporate business.

| | Number |
|---|---|
| 1. Members with Group Policies | |
| 2. Members with Medicare Policies | |
| 3. OMAP Members | |
| 4. Medicaid Members other than OMAP Members | |
| 5. Members with Individual Policies | |
| 6. Other Members | |
| 7. TOTAL MEMBERS | 0 |

**B.** For those entities that are not regulated by DCBS that have risk-based contracts, provide general membership information for your corporate business.

| | Number |
|---|---|
| 1. Members enrolled through a Workers' Compensation Risk-Based Contract. | |
| 2. Members enrolled through a Medicare Policy | |
| 3. OMAP Members | |
| 4. Medicaid Members other than OMAP Members | |
| 5. Members with Individual Policies | |
| 6. Other Members | |
| 7. TOTAL MEMBERS | 0 |

## EXHIBIT G – Attachment 6 - Report G.4.1 – OHP Chemical Dependency Service Utilization

**I.** Contractor_____

Report Period:_____ through _____

**II.** Report the total Member months during the report period.

**III.** Provide utilization, cost and OMAP Member information for chemical dependency services provided during the report period.

| Chemical Dependency Services | Number of Visits | Number of OMAP Members | Rate per 1000 OMAP Members per Report Period | Total Chemical Dependency Cost | Per Capita Cost |
|---|---|---|---|---|---|
| Outpatient Chemical Dependency Services | | | | | |
| Methadone Services | | | | | |
| Residential Services | | | | | |
| Outpatient CPMS Services | | | | | |
| Other Chemical Dependency Services | | | | | |

## EXHIBIT G – Attachment 7 - Report G.5 – Audited Yearly Balance Sheet of Corporate Activity

Contractor _____

Report Period: _____ through _____

| | | Corporate Total |
|---|---|---|
| CURRENT ASSETS | 1. Cash and cash equivalents | |
| | 2. Short-term investments | |
| | 3. Premiums Receivable | |
| | 4. Investment Income Receivables | |
| | 5. Health Care Receivables | |
| | 6. Amounts Due from Affiliates | |
| | 7. Reinsurance Recoverable on Paid Losses | |
| | 8. Other Current Assets | |
| 9. TOTAL CURRENT ASSETS | | - |
| OTHER ASSETS | 10. Bonds | |
| | 11.1 Preferred Stocks | |
| | 11.2 Common Stocks | |
| | 12. Other Long-Term Invested Assets | |
| | 13. Receivable for Securities | |
| | 14. Amounts Due from Affiliates | |
| | 15. Restricted Cash and Restricted Securities | |
| | 16. Other Assets | |
| 17. TOTAL OTHER ASSETS | | - |
| | 18. Land, Building and Improvements (net of depreciation) | |
| | 19. Furniture and Equipment (net of depreciation) | |
| | 20. Leasehold Improvements (net of depreciation) | |
| | 21. EDP Equipment (net of depreciation) | |
| | 22. Other Property and Equipment (net of depreciation) | |
| 23. TOTAL PROPERTY AND EQUIPMENT (net of depreciation) | | - |
| 24. TOTAL ASSETS | | - |

Details of Write-Ins (Lines 8, 16 and 22):

| | |
|---|---|
| | |
| | |
| | |
| | |

**Report G.5. Audited Yearly Balance Sheet of Corporate Activity (continued)**

Contractor _____

Report Period: _____ through _____

| | | Corporate Total |
|---|---|---|
| CURRENT LIABILITIES | 25. Accounts Payable | |
| | 26. Claims Payable | |
| | 27. Accrued Medical Incentive Pool | |
| | 28. Unearned Premiums | |
| | 29. Loans and Notes Payable | |
| | 30. Amounts Due to Affiliates | |
| | 31. Other Current Liabilities | |
| 32. TOTAL CURRENT LIABILITIES | | - |
| OTHER LIABILITIES | 33. Loans and Notes Payable | |
| | 34. Amounts Due to Affiliates | |
| | 35. Payable for Securities | |
| | 36. Other Liabilities | |
| 37. TOTAL OTHER LIABILITIES | | - |
| 38. TOTAL LIABILITIES | | - |
| NET WORTH | 39. Common Stock | |
| | 40. Preferred Stock | |
| | 41. Paid in Surplus | |
| | 42. Contributed Capital | |
| | 43. Surplus Notes | |
| | 44. Contingency Reserves | |
| | 45. Retained Earnings/Net Worth | |
| | 46. Other Net Worth | |
| 47. TOTAL NET WORTH | | - |
| 48. TOTAL LIABILITIES AND NET WORTH | | - |

Details of Write-Ins (Lines 31, 36 and 46):

| | |
|---|---|
| | |
| | |
| | |
| | |
| | |

**EXHIBIT G – Attachment 8 - Report G.6 – Audited Yearly Statement of Revenue, Expenses & Net Worth**

Contractor _____

Report Period: _____ through _____

| | | Corporate Total |
|---|---|---|
| REVENUES | 1. Premiums (Capitation & Maternity Revenue) | |
| | 2. Fee-For-Service | |
| | 3. Title XIX-Other Medicaid | |
| | 4. Net Investment Income | |
| | 5. Other Health Care-Related Revenues | |
| | 6. Non Health Care-Related Revenues | |
| 7. TOTAL REVENUES | | - |
| MEDICAL AND HOSPITAL EXPENSES | 8. Physician/Professional Services | |
| | 9. Hospital Services | |
| | a. Inpatient | |
| | b. Outpatient | |
| | c. Emergency Room | |
| | 10. Pharmacy | |
| | 11. Lab and X-ray | |
| | 12. Vision | |
| | 13. Chemical Dependency | |
| | 14. DME & Supplies | |
| | 15. Other Medical and Hospital Expenses | |
| 16. MEDICAL AND HOSPITAL EXPENSES SUBTOTAL | | - |

Details of Write-Ins (Lines 5,6, and 15):

| | | |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**Report G.6 – Audited Yearly Statement of Revenue, Expenses & Net Worth (continued)**

| | | Corporate Total |
|---|---|---|
| DEDUCTIONS | 17. Reinsurance Recoveries Incurred | |
| | 18. Co-payments | |
| | 19. TPR, COB, and Subrogation | |
| 20. DEDUCTIONS SUBTOTAL | | - |
| 21. TOTAL MEDICAL AND HOSPITAL EXPENSES LESS DEDUCTIONS | | - |
| ADMINISTRATIVE EXPENSES | 22. Compensation | |
| | 23. Marketing/Educational Materials | |
| | 24. Other Administrative Expense | |
| 25. TOTAL ADMINISTRATIVE EXPENSE | | - |
| 26. TOTAL EXPENSES | | - |
| 27. INCOME (LOSS) (before taxes) | | - |
| OTHER ITEMS | 28. MCO tax | |
| | 29. Provision for Income Taxes | |
| 30. NET INCOME (LOSS) | | - |
| NET WORTH | 31. Net Worth Beginning of Quarter | |
| | 32. Increase (Decrease) in Common Stock | |
| | 33. Increase (Decrease in Preferred Stock | |
| | 34. Increase (Decrease) in Paid in Surplus | |
| | 35. Increase (Decrease) in Contributed Capital | |
| | 36. Increase (Decrease) in Surplus Notes | |
| | 37. Increase (Decrease) in Contingency Reserves | |
| | 38. Increase (Decrease) in Retained Earnings/Net Worth: | |
| | a. Net Income | - |
| | b. Dividends to Stockholders | |
| | c. Interest on Surplus Notes | |
| | d. Change in Non-Admitted Assets | |
| | e. Other Changes | |
| | 39. Net Worth at End of Quarter | |

Details of Write-Ins (Lines 24 and 38e):

| | |
|---|---|
| | |
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| | |
| | |

**EXHIBIT G – Attachment 9 - Report G.7 – Quarterly Balance Sheet of Corporate Activity**

Contractor _____

Report Period: _____ through _____

| | | Corporate Total |
|---|---|---|
| CURRENT ASSETS | 1. Cash and cash equivalents | |
| | 2. Short-term investments | |
| | 3. Premiums Receivable | |
| | 4. Investment Income Receivables | |
| | 5. Health Care Receivables | |
| | 6. Amounts Due from Affiliates | |
| | 7. Reinsurance Recoverable on Paid Losses | |
| | 8. Other Current Assets | |
| 9. TOTAL CURRENT ASSETS | | - |
| OTHER ASSETS | 10. Bonds | |
| | 11.1 Preferred Stocks | |
| | 11.2 Common Stocks | |
| | 12. Other Long-Term Invested Assets | |
| | 13. Receivable for Securities | |
| | 14. Amounts Due from Affiliates | |
| | 15. Restricted Cash and Restricted Securities | |
| | 16. Other Assets | |
| 17. TOTAL OTHER ASSETS | | - |
| | 18. Land, Building and Improvements (net of depreciation) | |
| | 19. Furniture and Equipment (net of depreciation) | |
| | 20. Leasehold Improvements (net of depreciation) | |
| | 21. EDP Equipment (net of depreciation) | |
| | 22. Other Property and Equipment (net of depreciation) | |
| 23. TOTAL PROPERTY AND EQUIPMENT | | - |
| 24. TOTAL ASSETS | | - |

Details of Write-Ins (Lines 8, 16 and 22)

| | |
|---|---|
| | |
| | |
| | |

**Report G.7. Quarterly Balance Sheet of Corporate Activity (continued)**

| | | Corporate Total |
|---|---|---|
| CURRENT LIABILITIES | 25. Accounts Payable | |
| | 26. Claims Payable | |
| | 27. Accrued Medical Incentive Pool | |
| | 28. Unearned Premiums | |
| | 29. Loans and Notes Payable | |
| | 30. Amounts Due to Affiliates | |
| | 31. Other Current Liabilities | |
| 32. TOTAL CURRENT LIABILITIES | | - |
| OTHER LIABILITIES | 33. Loans and Notes Payable | |
| | 34. Amounts Due to Affiliates | |
| | 35. Payable for Securities | |
| | 36. Other Liabilities | |
| 37. TOTAL OTHER LIABILITIES | | - |
| 38. TOTAL LIABILITIES | | - |
| NET WORTH | 39. Common Stock | |
| | 40. Preferred Stock | |
| | 41. Paid in Surplus | |
| | 42. Contributed Capital | |
| | 43. Surplus Notes | |
| | 44. Contingency Reserves | |
| | 45. Retained Earnings/Net Worth | |
| | 46. Other Net Worth | |
| 47. TOTAL NET WORTH | | - |
| 48. TOTAL LIABILITIES AND NET WORTH | | - |

Details of Write-Ins (Lines 31, 36 and 46):

| | |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

## EXHIBIT G – Attachment 10 - Report G.8 – Quarterly Statement of Revenue, Expenses & Net Worth

Contractor _____

Report Period: _____ through _____

A. OHP Line of Business:

1. Are separate accounts kept for the OHP Business revenues, expenses and net worth? ___ Yes ___No

2. If separate accounts are not kept, describe the allocation method used and include

all underlining assumptions that justify the use of this method:

| | | OHP Contract Activity | Corporate Total |
|---|---|---|---|
| REVENUES | 1. Premiums | | |
| | 2. Fee-For-Service | | |
| | 3. Title XIX-Other Medicaid | | |
| | 4. Net Investment Income | | |
| | 5. Other Health Care Related Revenues | | |
| | 6. Non-Healthcare-Related Revenues | | |
| 7. TOTAL REVENUES | | - | - |
| MEDICAL AND HOSPITAL EXPENSES | 8. Physician/Professional Services | | |
| | 9. Hospital Services | | |
| | a. Inpatient | | |
| | b. Outpatient | | |
| | c. Emergency Room | | |
| | 10. Pharmacy | | |
| | 11. Lab and X-ray | | |
| | 12. Vision | | |
| | 13. Chemical Dependency | | |
| | 14. DME & Supplies | | |
| | 15. Other Medical and Hospital Expenses | | |
| 16. MEDICAL AND HOSPITAL EXPENSES SUBTOTAL | | - | - |

Details of Write-Ins (Lines 5,6, and 15):

| | | | |
|---|---|---|---|
| | | | |
| | | | |

**Report G.8 – Quarterly Statement of Revenue, Expenses & Net Worth (continued)**

| | | OHP Contract Activity | Corporate Total |
|---|---|---|---|
| DEDUCTIONS | 17. Reinsurance Recoveries Incurred | | |
| | 18. Co-payments | | |
| | 19. TPR, COB, and Subrogation | | |
| 20. DEDUCTIONS SUBTOTAL | | - | - |
| 21. TOTAL MEDICAL AND HOSPITAL EXPENSES LESS DEDUCTIONS | | - | - |
| ADMINISTRATIVE EXPENSES | 22. Compensation | | |
| | 23. Marketing/Educational Materials | | |
| | 24. Other Administrative Expense | | |
| 25. TOTAL ADMINISTRATIVE EXPENSE | | - | - |
| 26. TOTAL EXPENSES | | - | - |
| 27. INCOME (LOSS) (before taxes) | | | - |
| OTHER ITEMS | 28. MCO Tax | | |
| | 29. Provision for Income Taxes | | |
| 30. NET INCOME (LOSS) | | - | - |
| NET WORTH | 31. Net Worth Beginning of Quarter | | |
| | 32. Increase (Decrease) in Common Stock | | |
| | 33. Increase (Decrease in Preferred Stock | | |
| | 34. Increase (Decrease) in Paid in Surplus | | |
| | 35. Increase (Decrease) in Contributed Capital | | |
| | 36. Increase (Decrease) in Surplus Notes | | |
| | 37. Increase (Decrease) in Contingency Reserves | | |
| | 38. Increase (Decrease) in Retained Earnings/Net Worth: | | |
| | a. Net Income | - | - |
| | b. Dividends to Stockholders | | |
| | c. Interest on Surplus Notes | | |
| | d. Change in Non-Admitted Assets | | |
| | e. Other Changes | | |
| | 39. Net Worth at End of Quarter | - | - |

Details of Write-Ins (Lines 24, 38e):

| | |
|---|---|
| | |
| | |
| | |

## EXHIBIT G – Attachment 11 - Report G.8.1 – Net Worth Adjusted Medical Loss Ratio

Contractor _____

Report Period: _____ through _____

Please provide the following information and calculate the adjusted medical loss ratio to be used in determining the discounted premium to net worth ratio.

The adjusted medical loss ratio is defined as the result obtained when the OHP Line of Activity adjusted medical and hoptiatal expenses is divided by the OHP Line of Activity total revenue.

The adjusted medical and hospital expenses is calculated by subtracting the capitated service payments and the salaried service payments from the OHP Line of business medical and hospital expenses subtotal.

| Instructions | | Dollar Amounts |
|---|---|---|
| 1. Copy the dollar amount found on G8, Line 16, the OHP Contract Activity (Medical and Hospital Expenses Subtotal) | | |
| 2. Copy the Total of All Systems amount found on G10, II. A. Service Payment Arrangements, Salary Payments. | | |
| 3. Sum the five dollar amounts for the Total of All Systems found on G10, II. A. Service Payment Arrangements, Capitation Payments to Affiliated Provider and copy that amount here. | | |
| 4. Subtract Lines 2, 3, and 4 from Line 1 | | |
| 5. Copy the dollar amount found on G8, Line 7, the OHPContract Activity (Total Revenue). | | |
| 6. Divide Line 4 by Line 5. This number is the adjusted medical loss ratio and needs to be reported to the fourth decimal place. If the adjusted medical loss ratio is less than .2000, the adjusted medical loss ratio used in the premium to surplus ratio will be .2000. | | |

## EXHIBIT G – Attachment 12 - Report G.8.2 – OHP Medical Loss Ratios

Contractor _____

Report Period: _____ through _____

*(All amounts are per "OHP Contract Activity Column")*

Total Revenues per Line 7, Report G8 _____

Less: Taxes and Assessments-
MCO Tax per Line 28, Report G8
Income Taxes per Line 29, Report G8
Other (describe_____) _____
Total Taxes and Assessments _____

Net Revenue Available for Medical Expenses _____

Total Medical and Hospital Expenses per Line 21, Report G8 _____

OHP Medical Loss Ratio

**EXHIBIT G – Attachment 13 - Report G.9 – Cash Flow Analysis Corporate Activity/Indirect Method**

Contractor _____

Report Period: _____ through _____

Provide the cash flow information for Corporate Activity. Note that cash flows resulting from an increase in operating assets, a decrease in operating liabilities, and a payment out are debits. Note that cash flows resulting in receipt of cash or proceeds are credits.

| CASH FLOWS PROVIDED BY | **Operating Activities:** | Corporate Activity |
|---|---|---|
| Adjustment to reconcile net income (loss) to net cash | 1. Net Income (loss) | |
| | 2. Depreciation and Amortization | |
| Increase (Decrease) in Operating Assets | 3. Premium Receivable | |
| | 4. Due from Affiliates | |
| | 5. Health Care Receivable | |
| | 6. Other (increase) decrease in Operating Assets | |
| Increase (Decrease) in Operating Liabilities | 7. Accounts Payable | |
| | 8. Claims Payable | |
| | 9. Accrued Medical Incentive Pool | |
| | 10. Unearned Premiums | |
| | 11. Due to Affiliates | |
| | 12. Other Increase (Decrease) from Operating Activities | |
| 13. NET CASH PROVIDED (USED) FROM OPERATING ACTIVITIES | | - |

| CASH FLOWS PROVIDED BY | | Corporate Activity |
|---|---|---|
| CASH FLOWS PROVIDED BY INVESTING ACTIVITIES | 14. Receipts from Investments | |
| | 15. Receipts for Sales of Property and Equipment | |
| | 16. Payments for Investments | |
| | 17. Payments for Property and Equipment | |
| | 18. Other Increase (Decrease) in Cash Flow for Investing Activities | |

**Report G.9 – Cash Flow Analysis Corporate Activity/Indirect Method (cont.)**

| | | |
|---|---|---|
| 19. NET CASH PROVIDED BY INVESTING ACTIVITIES | | - |
| CASH FLOWS PROVIDED BY FINANCING ACTIVITIES | 20. Proceeds from Paid in Capital or Issuance of Stock | |
| | 21. Loan Proceeds from Non-Affiliates | |
| | 22. Loan Proceeds from Affiliates | |
| | 23. Principal Payments on Loans from Non-Affiliates | |
| | 24. Principal Payments on Loans from Affiliates | |
| | 25. Dividends Paid | |
| | 26. Principal Payments under Lease Obligations | |
| | 27. Other Cash Flow Provided by Financing Activities | |
| 28. NET CASH PROVIDED BY FINANCING ACTIVITIES | | - |
| 29. NET INCREASE/ (DECREASE) IN CASH AND CASH EQUIVALENTS | | - |
| 30. CASH AND CASH EQUIVALENTS AT BEGINNING OF REPORT PERIOD | | |
| 31. CASH AND CASH EQUIVALENTS AT END OF REPORT PERIOD | | - |

# EXHIBIT G – Attachment 14 - Report G.10 – Corporate Relationships of Contractors

Contractor _____

Report Period: _____ through _____

**PART I. Corporate Relationships and Organizational Structure**

**A.** Provide an organizational chart **with your submittal on August 31st or if a change occurs during the current report quarter** indicating the relationship of Contractor to the full corporate structure, including all entities, all subsidiaries, all affiliates and all organizations fully or partially owned by other entities in the corporate family. If your company is not registered under a Holding Company Act, illustrate the direct parent or controlling person, if any.

**B.** Does a financial guarantee agreement exist between Contractor and any parent entity? If so, provide the current annual audited financial statement of the parental entity.

**C.** OMAP requires Contractors to provide financial information for purposes of evaluating financial information for purposes of evaluating financial solvency that, but for the Contract, would not be disclosed to individuals or entities outside of the Contractor's organization. Under ORS 192.501(2), OMAP may conditionally withhold from disclosure records that meet all four of the following criteria:

**1** The information must not be patented;
**2** The information must be known only to certain individuals within the organization and used for business the organization conducts;
**3** The information must have actual or potential commercial value; and
**4** The information must give its users an opportunity to obtain a business advantage over competitors who do not know or use it.

Indicate whether Contractors consider any of the following financial records submitted to OMAP under the contract to meet all of the above listed criteria:

_____ Service Payment Arrangement Form (Part II)
_____ Incentive Arrangement Form (Part III)
_____ Intermediate Arrangement Form (Part VI)
_____ Model Depository Agreement Form and attachments.
_____ Bank Statements; if any
_____ Other; please identify _____

_____

## Report G.10 – Corporate Relationships of Contractors (continued)

### PART II. Summary of Risk-Sharing Transactions with Provider Groups

**A.** Provide the total aggregate amount of payment made by Contractor to each health care delivery systems by service payment arrangement for the OHP line of business during the report quarter.

| | Service Payment Arrangements | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Health Care Delivery Systems | Salary Payments | Fee-For-Service Payments | Capitation Payments to Affiliated Providers | | | | | Payments to Non-Affiliated Providers | Stop Loss Premium |
| | | | Primary Care Providers | Specialist Providers | Lab/ X-ray Providers | Hospital Providers | Other Providers | | |
| IPA | | | | | | | | | |
| Primary Care Practitioners | | | | | | | | | |
| Specialist Practitioners | | | | | | | | | |
| Lab/X-ray Service Providers, Individual or Group | | | | | | | | | |
| Hospital Providers, Individual or Group | | | | | | | | | |
| Other Inpatient Providers | | | | | | | | | |
| Other Providers, Individual or Group | | | | | | | | | |
| Total of All Systems | - | - | - | - | - | - | - | - | - |

**Report G.10 – Corporate Relationships of Contractors (continued)**

Contractor _____

Report Period: _____ through _____

**PART III. Total Incentive Arrangements** (due August 31 each year)

1. Does the Contractor have incentive arrangements with Providers? Yes ____ No _____
2. If yes, then provide the total dollar amount of total Provider reimbursement associated with the Provider bonus, capitation withhold, and fee-for-service withholds as stipulated in any incentive arrangement for provision of services for the OHP line of business during the current report quarter. Type either a (Y)es or (N)o to indicate if Providers are allowed participation in multiple or group/individual-based risk pools and to indicate the frequency of payout. If applicable, briefly describe Contractor's risk pool arrangements by health care delivery system. If Contractor has withhold incentive arrangements with any health care delivery system, list the Provider responsible for deficits in excess of the withhold for each arrangement by health care delivery system.

| Health Care Delivery Systems | Total Incentive Arrangements | | | | | | Name of Provider Responsible for Deficits in Excess of Withhold | Frequency of Payout | |
|---|---|---|---|---|---|---|---|---|---|
| | Provider Bonus | Capitation Withhold | Fee-For-Service Withhold | Total Across Delivery System | Are Providers Allowed Participation in Multiple Risk Pools | Are Providers Allowed Group/Individual Based Risk Pools | | Annual | More than Once a Year |
| IPA | Total Dollar Amount | Total Dollar Amount | Total Dollar Amount | | Y N | Y N | | Y N | Y N |
| Primary Care Practitioners | | | | | Y N | Y N | | Y N | Y N |
| Specialist Practitioners | | | | | Y N | Y N | | Y N | Y N |
| Lab/X-ray Service Providers, Individual or Group | | | | | Y N | Y N | | Y N | Y N |
| Hospital Providers, Individual or Group | | | | | Y N | Y N | | Y N | Y N |
| Other Inpatient Providers | | | | | Y N | Y N | | Y N | Y N |
| Other Providers, Individual or Group | | | | | Y N | Y N | | Y N | Y N |
| TOTAL | | | | | | | | | |

## Report G.10 – Corporate Relationships of Contractors (continued)

Contractor _____

Report Period: _____ through _____

### PART IV. Intermediary Arrangements

**1** Please detail the administrative and medical/hospital/dental expenses paid by the Corporate Entity to Intermediaries to perform the duties associated with the OHP Line of Business only. The attachment need only be completed if the Contractor pays 16% or more of its total administrative expenses to an individual intermediary or more than 25% of the OMAP premium revenue in a month to any individual intermediary to provide medical/hospital/dental services. If Contractor meets this standard, please complete this attachment by showing these expenses in the appropriate expense classification. Allocate the costs to the appropriate expense classification as if the expenses were borne directly by the Contractor.

| | | Services Paid by Corporate Entity to Intermediaries |
|---|---|---|
| Administrative Expenses | 1. Total Salary and Wages/Compensation | |
| | 2. External Utilization Management Fees | |
| | 3. External Certifications and accreditation Fees | |
| | 4. External Legal fee and expenses | |
| | 5. External Auditing, actuarial, & other consulting services | |
| | 6. Marketing and advertising | |
| | 7. Claims processing | |
| | 8. Reimbursements from intermediaries | |
| | 9. Reimbursements to intermediaries | |
| | 10. Other administrative expenses | |
| | 11. Total administrative expense | |
| Medical/Hospital/Dental Expenses | 12. Physician/Professional Services | |
| | 13. Hospital Services | |
| | a. Inpatient | |
| | b. Outpatient | |
| | c. Emergency Room | |
| | 14. Pharmacy | |
| | 15. Lab and X-ray | |
| | 16. Vision | |
| | 17. Chemical Dependency | |
| | 18. DME & Supplies | |
| | 19. Incentive Pool and Withhold Adjustments | |
| | 20. Other Medical and Hospital Expenses | |
| | 21. Total Medical/Hospital/Dental Expenses | |

# EXHIBIT G – Attachment 15 - Report G.11

1. Fill out the claims lag form below for the corporate line of business. Show the payment activity for each month, indicating on each line a paid month, the dollar amount of Claims paid in the incurred month, the dollar amount of Claims paid one, two, three, four, five or six months after incurred, and the total dollar amount of Claims paid. Please note that the months are in descending order.

| PAID THRU MONTH | ENDING MONTH | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | INCURRED MONTH | INCURRED 1 MONTH | INCURRED 2 MONTH | INCURRED 3 MONTH | INCURRED 4 MONTH | INCURRED 5 MONTH | INCURRED 6 MONTH | ALL OTHER PRIOR MONTHS | PAID TOTAL |
| 1 | | | | | | | | | |
| 2 | | | | | | | | | |
| 3 | | | | | | | | | |
| 4 | | | | | | | | | |
| 5 | | | | | | | | | |
| 6 | | | | | | | | | |
| 7 | | | | | | | | | |
| 8 | | | | | | | | | |
| 9 | | | | | | | | | |
| 10 | | | | | | | | | |
| 11 | | | | | | | | | |
| 12 | | | | | | | | | |
| 13 | | | | | | | | | |
| TOTALS | | | | | | | | | |

| PAID THRU MONTH | ENDING MONTH | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | INCURRED MONTH | INCURRED 1 MONTH | INCURRED 2 MONTH | INCURRED 3 MONTH | INCURRED 4 MONTH | INCURRED 5 MONTH | INCURRED 6 MONTH | ALL OTHER PRIOR MONTHS | PAID TOTAL |
| 1 | | | | | | | | | |
| 2 | | | | | | | | | |
| 3 | | | | | | | | | |
| 4 | | | | | | | | | |
| 5 | | | | | | | | | |
| 6 | | | | | | | | | |
| 7 | | | | | | | | | |
| 8 | | | | | | | | | |
| 9 | | | | | | | | | |
| 10 | | | | | | | | | |
| 11 | | | | | | | | | |
| 12 | | | | | | | | | |
| 13 | | | | | | | | | |
| TOTALS | | | | | | | | | |

| PAID THRU MONTH | ENDING MONTH | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | INCURRED MONTH | INCURRED 1 MONTH | INCURRED 2 MONTH | INCURRED 3 MONTH | INCURRED 4 MONTH | INCURRED 5 MONTH | INCURRED 6 MONTH | ALL OTHER PRIOR MONTHS | PAID TOTAL |
| 1 | | | | | | | | | |
| 2 | | | | | | | | | |
| 3 | | | | | | | | | |
| 4 | | | | | | | | | |
| 5 | | | | | | | | | |
| 6 | | | | | | | | | |
| 7 | | | | | | | | | |
| 8 | | | | | | | | | |
| 9 | | | | | | | | | |
| 10 | | | | | | | | | |
| 11 | | | | | | | | | |
| 12 | | | | | | | | | |
| 13 | | | | | | | | | |

**EXHIBIT G – Attachment 16 - Report G.12 – Physician Incentive Plan Disclosure Form – Contractor Relationships**

This following report is a modified form (OMB No. 0938-0700). DMAP will accept either the following Physician Referral Incentive Relationship Form or the CMS PIP Disclosure Form (OMB No. 0938-0700) to determine compliance with 42 CFR 422.208-422.210. This report shall be submitted **annually** with the second quarter reports due August 15th of each calendar year. Contractor is also required to submit these forms when service area designations are changed or when there is an incentive arrangements change in any subcontract Contract with plan Providers. It is expected that all contractual levels in place between the Contractor and any physician providing services to Medicaid members will be disclosed.

Cover Sheet

PHYSICIAN INCENTIVE PLAN DISCLOSURE FORM
DMAP Contractor's Disclosure Compliance Package
Under the Physician Incentive Regulation

Name of Contractor _____

Contractor is owned/controlled by a Federally Qualified Health Center or Rural Health Clinic (FQHC/RHC) or consortium of FQHC/RHCs or includes FQHC/RHCs in its network:

YES _____ ; NO _____

Printed Name of Contractor's Contact Person _____

Phone # _____

**This represents our organization's disclosure compliance package submitted to DMAP. I certify that the information made in this disclosure is true, complete and current to the best of my knowledge, information and belief and is made in good faith.**

Printed Name of CEO _____

Signature of CEO _____ Date: _____

Note: Please include this Cover Sheet as the first page of the Contractor's Disclosure Compliance Package.

**Report G.12 – Physician Incentive Plan Disclosure Form – Contractor Relationships (continued)**

## PHYSICIAN INCENTIVE PLAN DISCLOSURE FORM

Contractor Name: _____
Reporting year: _____

Note: Disclosure is required even if risk or substantial risk is not being transferred or panel exceeds 25,000.

**CHECK ONE** - Use this Disclosure Form to disclose the incentive arrangement between the first party (in the list below) that contracts with a second party (underlined on list below) for services to the Contractor's Medicaid enrollees. **Be sure to disclose subcontracting arrangements down to physician levels**.

-- Repeat forms as many times as needed to capture the various levels of contractual relationships.
-- For simplicity, "Provider" is used here to refer to the second party. See instructions for completing this Form under "Single or aggregate disclosure" for aggregating either the first or second party.
-- The CMS Provider Data Worksheet can be the basis for this summary form. All forms and instructions are available at: http://www.cms.hhs.gov/manuals/downloads/mc86c06.pdf.

(1) _____ Contractor to physician group

(2) _____ Contractor to intermediate entity

(3) _____ Contractor to individual physician

(4) _____ Intermediate entity to physician group

(5) _____ Intermediate entity to physician

(6) _____ Physician group to physician group

(7) _____ Physician group to physician

(8) _____ Physician to physician

(9) _____ Intermediate entity to intermediate entity

**1. Provider(s) named or counted should be the underlined Provider in the line checked above.**

**A.** Name or Identifier of Provider: _____. Use the actual name or any identifier for the entity or aggregated entities disclosed on this chart.

**B.** Number of Providers in the category selected: _____. Give # of Providers who are aggregated on this form; e.g., if this form is for physician groups, category #1, then give the # of physician groups; groups can be aggregated if risk arrangements are substantially the same and stop loss requirements are the same.

**C.** Is Provider an FQHC/RHC? **Y**es _____; **N**o _____
If Providers are aggregated, see instructions for disclosing FQHCs.

**D.** If #7 above is selected, give number of physicians who are:
**M**embers (e.g. owners, employees) of the group #_____ ; **C**ontracted with the group #_____.These numbers must equal the number of physicians given in I.B.

**Report G.12 – Physician Incentive Plan Disclosure Form – Contractor Relationships (continued)**

NOTE: If either #2 or #9 is checked above, this form is complete since stop loss requirements do not apply to intermediate entities (IE). However, be sure to complete disclosures for the IE's relationships with Provider groups and their physicians (#4 and #7) and with individual physicians (#5) because stop loss requirements apply to these levels.

**2.** Is risk transferred to the Provider? **Y**es _____; **N**o _____
Note: A bonus for low utilization of referral services is considered to be risk transference.
If YES, check all the risk transfer methods with the Provider and go to question 3.

**C**apitation _____; **B**onus _____; **W**ithhold _____; **P**ercent of Premium_____; **O**ther _____
Note: Consider the obligation for the Provider to fund deficits as a "withhold".
Describe briefly:

**3.** Is risk transferred for referrals? **Y**es _____; **N**o _____
Note: A bonus for low utilization of hospital, specialist or other services is considered to be at risk for referral services. If NO, this chart is finished. If YES, proceed to next question.

**4.** Check all the referral risk transfer methods with the Provider and go to question 5.

**C**apitation _____; **B**onus _____; **W**ithhold _____; **P**ercent of Premium_____; **O**ther _____
Note: Consider the obligation for the Provider to fund deficits as a "withhold".
If needed, describe briefly:

**5.** What percent of the total potential payment is at risk for referrals: _____%
If above 25% proceed to question 6; if 25% or below you have completed this disclosure.

**6.** Number of Contractor's patients served by the Provider **or** the number of pooled patients, if patients can be pooled (see criteria for pooling in the instructions). Check one category:

**A** __ 1-1,000; **B** __ 1,001-5,000; **C** __ 5,001-8,000; **D** __ 8,001-10,000; **E** __ 10,001- 25,000; **F**__ 25,000+

If number is 25,000 or below, answer #7. If the number exceeds 25,000, you have completed this disclosure.

**7.** State the type and amount of stop loss insuring the physician group and/or physician:
Aggregate insurance is excess loss coverage that accumulates based on total costs of the entire population for which they are at risk and which reimburses after the expected total cost exceeds a pre-determined level. Individual insurance is where a specific Provider excess loss accumulates based on per member per year Claims.

Type: **A**ggregate _____; **I**ndividual _____; **O**ther _____ [describe below if aggregate or other]

If individual [based on costs per patient], enter threshold/deductible amount: [enter only one amount]
_____Threshold: **P**rofessional $_____ ; **I**nstitutional $_____ ; **C**ombined $_____ Describe, if needed:

# EXHIBIT H - Encounter Data Minimum Data Set Requirements and Corrective Action.

## Introduction

The information in this Exhibit H applies to Encounter Data Transaction procedures for dates of service in effect on and after the date this Contract was signed. The parties to this Contract acknowledge and agree that the Contractor will transmit data to DMAP using the Health Insurance Portability and Accountability Act (HIPAA) Transaction Standards for Health Care Claims Data as specified in 45 CFR 162.1101 and 162.1102.

- Contractor shall take all necessary actions required by DHS to become a trading partner and to register and conduct data transactions. The parties shall comply with DHS Electronic Data Interchange (EDI) Rules, OAR 410-001-0100 et seq., applicable to the conduct of HIPAA Standard Transactions with trading partners.

- Upon Contractor's compliance with testing and other requirements in the DHS EDI rules, and when DHS determines that Encounter Transactions may be placed into the production environment, Contractor shall submit encounter data that complies with the data requirements of this Exhibit.

The parties understand and agree that this Exhibit H may be further amended for purposes of complying with 45 CFR Parts 160 and 162.

## 1. General Provisions

### a. Encounter Definitions

An "Encounter" is a service or bundle of medically related services provided to one DMAP Member by one Provider in one time period. Encounters are divided into Medical, Inpatient Hospital, Nursing Facility and Outpatient (including Outpatient Hospital, Outpatient Nursing Facility, Kidney Dialysis, Home Health and Hospice).

**(1)** **"Adjudicated Encounters"** are Claims that process through DMAP system edits.

**(2)** **"Corrective Action Plan"** is an DMAP initiated request for Contractor to develop and implement a time specific plan, that is acceptable to DMAP, for the correction of DMAP identified areas of noncompliance, as described in this Exhibit and Exhibit B, Part II, Section 2, Sanctions.

**(3)** **"Encounter Data"** means health care Claims or equivalent encounter information transaction transmitting either of the following:

**(a)** A request to obtain payment, and the necessary accompanying information from a Provider to Contractor, for health care or

**(b)** If there is no direct Claim, because the reimbursement contract is based on a mechanism other than charges or reimbursement rates for specific services, the transaction of encounter information for the purpose of reporting Contractor's health care.

**(4)** **"Encounter Only Provider"** is a Provider that provides Medicaid services to OHP Clients only as a Subcontractor to Contractor.

**(5)** **"Inpatient Hospital and Inpatient Nursing Facility Encounters"** are services provided by a facility to an DMAP Member who has been admitted to the facility as an Inpatient, as defined in the DMAP administrative rules, for the purposes of receiving services.

**(6)** **"Medical Encounters"** are professional and ancillary services including durable medical equipment (DME) and medical transportation.

**(7)** **"Nursing Facility"** means an establishment, which is licensed and certified by Seniors and People with Disabilities (SPD).

**(8)** **"Outpatient Hospital", "Outpatient Nursing Facility", "Kidney Dialysis", "Home Health", and "Hospice Encounters"** are services provided by a facility to a DMAP Member who has not been admitted to the facility as an Inpatient, as defined in the DMAP administrative rules, for the purposes of receiving services.

**(9)** **"Pended Encounters"** are Encounters with critical errors that will not process through DMAP system edits because of missing or erroneous data

**(10)** **"Report Errors"** are Encounters that will process through DMAP system edits. They are, however, a notice to Contractor to review the Encounter for errors such as inaccurate coding, maximum unit exceeded or contract limitations. Examples: services provided below the Health Services Commission (HSC) line.

**(11)** **"Repended Encounters"** are Pended Encounters that Pend again during the adjustment process.

**(12)** **"Validation Period"** is the Contract Year, beginning January 1 and ending December 31 of the Contract period, or as specified in a duly executed amendment.

**b. Encounter Data Submission and Processing**

**(1)** Contractor must submit Encounter Data at least once per calendar month. The Encounter Data must represent at least 50% of all Encounter types received and adjudicated by Contractor that month.

**(2)** Contractor shall submit all initial and unduplicated Encounter Data to DMAP within 180 days of the date of service.

**(3)** DMAP will Pend Encounter Data if the Encounter Data cannot be processed because of missing or erroneous information.

**(4)** DMAP will notify Contractor of the status of all Encounter Data processed. Notification of all Pended Encounter Data shall be provided to Contractor each week that an Encounter remains Pended.

**(5)** Contractor shall submit corrections to all Pended Encounters within 63 days of the date DMAP sends Contractor notice that the Encounters were Pended. Claims for correction that are not submitted within 63 days are subject to Corrective Action. See Section 4, Subsection c, Timeliness Errors in Resubmitted Encounters.

**(6)** To prevent Corrective Action, Contractor may submit documentation to DMAP citing specific circumstances that delay Contractor's timely submittal of adjusted or original Encounter Data (within 180 days from the date of service). DMAP will review the documentation and make a determination within 30 days on whether the circumstances cited are Acceptable. These "Acceptable" circumstances may include, but are not limited to:

**(a)** DMAP Member's failure to give the Provider necessary Claim information,

**(b)** Third-Party Resource liability coordination,

**(c)** Delays associated with resolving out-of-area Claims,

**(d)** DMAP Member pregnancy,

**(e)** Third-Party submitter coordination,

**(f)** Hardware or software modifications,

**(g)** Staffing, and

**(h)** DMAP recognized system issues preventing timely submission of corrections.

**(7)** Contractor shall submit Encounter Data, for all services rendered to Contractor's enrolled DMAP Members under this Contract, including Encounters where Contractor determined no liability exists. Contractor shall submit Encounter Data even if the Contractor did not make any payment for a Claim, including Claims for services to enrolled DMAP Members provided under subcontract, capitation or special arrangement with another facility or program. Contractor shall submit Encounter Data for all services provided under this Contract to DMAP Members who also have Medicare coverage, if a Claim has been submitted to Contractor.

**(8)** Contractor shall include a provision in all Subcontracts that to the extent any provision in this Contract applies to Contractor with respect to the Work Contractor is providing to DMAP under a Subcontract, that provision shall be incorporated by reference into the Subcontract and shall apply equally to Subcontractor.

**(9)** Contractor shall not submit known exact duplicate Encounters to DMAP. DMAP may ask Contractor to participate in a Corrective Action Plan, if more than 10% of Contractor's monthly submissions contain exact duplicate Encounters.

**c. Data Transmission and Format**

Contractor must submit all Encounter Data to DMAP electronically.
Contractor must submit all data in an 837 HIPAA Compliant format and as set forth in HIPAA's Implementation Guides, DHS' 837 Companion Guides and system specifications supplied by DMAP.

**d. Data Set Requirements**

**(1)** The Data Elements specified in this section constitute the minimum data elements required for DHS processing. Non-compliance shall be considered a breach of the terms of this Contract.

**(2)** Contractor shall submit the following identifying information for all Encounters:

**(a)** Contractor's DMAP PHP Provider number, or the National Plan Identifier, when available,

**(b)** DMAP Member name,

**(c)** DMAP Member number, also known as the DMAP prime number, and

**(d)** Valid Claim Adjustment Reason Code(s) (CARC) (Contractor's determination at the service line that a liability exists).

**(3)** For Medical Encounters, in addition to the identifying information listed in Paragraph (2), of this subsection, DHS requires an 837P format and the following minimum data elements for DHS processing of Encounters:

**(a)** For the billing and rendering Provider the NPI and Provider Taxonomy Code, as applicable, must be used pursuant to 45 CFR 162.410 and 162.412.

**(b)** ICD-9-CM diagnosis code(s) at the highest level of specificity,

**(c)** Date(s) of service,

**(d)** Modifier(s) (if applicable),

**(e)** Procedure code(s) (e.g., CPT, HCPC),

**(f)** Line item charge(s) based on the usual and customary charge(s) even though a Third Party Resource has made complete or partial payment, and

**(g)** Quantity of units of service.

**NOTE:** DME supplies provided by a pharmacy must be submitted in the HIPAA 837 Professional format.

**(4)** For Outpatient Hospital, in addition to the identifying information listed in Paragraph (2), of this subsection, DHS requires an 837I format and the following minimum data elements for DHS processing of Encounters:

**(a)** For the facility Provider the NPI and Provider Taxonomy Code, as applicable, must be used, pursuant to 45 CFR 162.410 and 162.412.

**(b)** Revenue center code(s) (National Uniform Billing Committee (NUBC) Rule),

**(c)** Date of service for each line item,

**(d)** Quantity of units of service,

**(e)** Line item charge(s) based on the usual and customary charge(s) even though a Third Party Resource has made complete or partial payment,

**(f)** ICD-9-CM diagnosis code(s) at the highest level of specificity, and

**(g)** Procedure codes (e.g. CPT/HCPCs) for the revenue center codes.

**(5)** For Inpatient Hospital and Inpatient Nursing Facility (NF) Encounter(s), in addition to the identifying information listed in Paragraph (2) of this subsection, DHS requires an 837I format and the following minimum data elements for DHS processing of Encounters:

**(a)** For the Nursing Facility Provider the NPI and Provider Taxonomy Code, applicable, must be used pursuant to, 45 CFR 162.410 and 162.412.

**(b)** Type of admission code,

**(c)** Patient discharge status code,

**(d)** Date(s) of service (dates from admission through discharge, except continuous stay NF clients use the last day of the month for the discharge date),

**(e)** Revenue center code(s) for the accommodation and ancillary services,

**(f)** Line item charges,

**(g)** Total charge,

**(h)** ICD-9-CM diagnosis code(s) at the highest level of specificity,

**(i)** ICD-9-CM procedure code(s) when a procedure is performed, and

**(j)** As required by 45 CFR 162.410 and 162.412, the NPI is required in place of any other number. The Provider's license number is not acceptable as a Provider number.

Contractor must submit one Inpatient Hospital Encounter per hospitalization. The Inpatient Hospital Encounter must represent all hospital services delivered to the DMAP Member. Interim and late billings are prohibited. Additional services or revisions to the original Encounter must be handled through the adjustment process. Inpatient Nursing Facility Encounters must be submitted for the actual dates of service for each calendar month. The Discharge Status Code for Nursing Facility patients who are not discharged shall be "30".

**2. Submission Standards**

**a.** The use of DMAP default Provider numbers including default NPIs are not acceptable as a Provider number. Only NPI and taxonomy codes for covered entities registered with DMAP are allowed in Encounter Data. Legacy Provider numbers are allowed for DMAP enrolled atypical Providers only.

**b.** **Contractor** shall not delete Pended Encounter Data for the sole purpose of avoiding Corrective Action. Contractor may only delete Pended Encounter Data that DMAP has determined cannot be corrected or through other mutually agreed upon reasons.

**c.** **Contractor** must make adjustments to Encounter Data when Contractor discovers the data are incorrect or no longer valid.

**d.** **If** DMAP discovers errors with previously Adjudicated Encounter Data defined in this Exhibit for that Contract Year resulting from a federal or State mandate or request that requires the completeness and accuracy of the Encounter Data, Contractor shall be required to correct the errors.

**e.** **DMAP** will not impose Sanctions on Contractor for Encounter Data affected by DMAP system limitations.

**f.** **Contractor** shall ensure that all Contractors' subcontracted Providers are enrolled with DMAP as either a Medicaid Provider or an Encounter Only Provider prior to submission of Encounter Data. Encounter Only Providers are enrolled using DMAP Form 3108, available at: http://egov.orgon.gov/DHS/healthplan/forms/omapforms.shtml#3100. A Form 3108 submitted without all required information will not be accepted and will be returned to Contractor.

**3. Error Types and Data Elements**

**a. Error Types**

DMAP will look for the following types of errors when validating Encounter Data:

**(1)** **"Accuracy Errors"** are differences between the information in Contractor's DMAP Member medical records and the Encounter data reported by Contractor to DMAP.

**(2)** **"Inadequate Submission Errors"** occur when Contractor fails to submit at least once per calendar month. The Claims must represent at least 50% of all the Encounters received and adjudicated by Contractor that month.

**(3)** **"Missing Medical Record Errors"** are Encounters Data that the Contractor is unable to provide the complete medical record.

**(4)** **"Omission Errors"** are Encounters that are not submitted to DMAP.

**(5)** **"Resubmission Errors"** are Pended Encounters that have been resubmitted for correction and Pend for errors after resubmission.

**(6)** **"Timeliness Errors"** are Encounters for which the time period between the date the Encounter is submitted to DMAP by Contractor and the date of service is greater than 180 days.

**(7)** **"Timeliness Errors in Resubmitted Encounters"** are Pended Encounters that Contractor has not resubmitted within 63 days of the date DMAP sends Contractor a notice that the Encounters were Pended. Timeliness Errors occur each 63 days thereafter that the Pended Encounter remains on the Pend file without successfully being corrected.

**(8)** **"Timeliness In Corrective Action Errors"** are Encounters for which Contractor has not submitted corrections within 63 days of the date DMAP sends Contractor a notice that Encounters need to be corrected.

**b. Data Elements for Validation Methodology**

**(1)** For purposes of Corrective Action, DMAP shall consider the required data elements listed in Section 1, Subsection d, Data Set Requirements, of this Exhibit.

**(2)** DMAP may conduct validations, quality checks and analyses of Encounter Data previously received from Contractor at DMAP's sole discretion and without notice to Contractor.

## 4. Timeliness

DMAP will not take Corrective Action for Timeliness Errors, if the error occurred as the result of a DMAP Encounter Data system problem and are beyond the control of the Contractor. If the Timeliness errors are the result of Contractor's Encounter Data system breakdown, Contractor may provide documentation to DMAP. DMAP will review Contractor's documentation before determining if Corrective Action is indicated.

**a. Timeliness Errors**

**(1) Schedule**

For the purposes of validating Encounter Data for Timeliness Errors, DMAP will collect and tabulate information in the DMAP Encounter Data system once every three months during the Contract Year, at DMAP's sole discretion, and without notice to Contractor.

**(2) Method**

**(a)** The unit of analysis is the date of service on the Encounter.

**(b)** Definition of Method

**(ii)** The number of Encounters submitted to the DMAP Encounter Data system with a date of service greater than 180 days from date of service until submission to DMAP is tabulated weekly.

**(iii)** If the number of Encounters submitted over 180 days from the date of service exceeds 10% of the Encounter Data submitted, Corrective Action may be initiated.

**b. Resubmission** Errors

**(1) Schedule**

For the purposes of validating Encounter Data for Resubmission Errors, DMAP will collect and tabulate information in the DMAP Encounter Data system no less than once every three months during the Contract Year, at DMAP's sole discretion, and without notice to Contractor.

**(2) Method**

**(a)** The unit of analysis is the number of Pended Encounters that have been resubmitted.

**(b)** Definition of Method

**(i)** The number of Pended Encounters resubmitted to the DMAP Encounter Data system that Pend again are calculated weekly.

**(ii)** If the number of resubmitted Encounters that Pend again exceeds 10% of resubmitted Encounters, Corrective Action may be initiated.

**c. Timeliness Errors in Resubmitted Encounters**

**(1) Schedule**

For the purposes of validating Encounter Data for timeliness in resubmitted Encounters, DMAP will collect and tabulate information in the DMAP Encounter Data system no less than once every three months during the Contract Year, at DMAP's sole discretion, and without notice to Contractor.

**(2) Method**

**(a)** The initial unit of analysis is the original Pend notification date and date of resubmitted Pended Encounters as determined by the Internal Control Number (ICN), or lack of resubmission of Pended Encounters by the notification date. Subsequent units of analysis are set at 63 day intervals after the initial deadline date (63 days from original notification).

**(b)** Definition of Method

The number of Encounters Pended in the DMAP Encounter Data system with a Pend date greater than 63 days before resubmission to DMAP, or Encounters that are not resubmitted to DMAP is calculated weekly. Thereafter, the number of Encounters that remain Pended in the DMAP Encounter Data system in 63-day increments is calculated until the Encounters adjudicate.

## 5. Validation Methodology

DMAP may draw samples from Enrollment information and Encounter Data for the purpose of performing validation audits, to be consistent with the protocol for Validating Encounter Data, set forth by the Department of Health and Human Services, Centers for Medicare & Medicaid Services, available at: http://www.cms.hhs.gov/MedicaidManagCare/ .

### a. Omission Errors

#### (1) Schedule

Omission Errors are not tabulated continuously as part of the Encounter Data system; therefore, an annual sampling of Contractor's DMAP Member medical records, as provided by Contractor's Provider, is required in order to assess these errors. For the purposes of validating Encounter Data for Omission Errors, DMAP, or its designee, may collect information from Contractor's DMAP Member medical records. DMAP, or its designee, shall give Contractor no less than 30 days written notice prior to reviewing or collecting information from Contractor's DMAP Member medical records. Contractor shall submit medical records to DMAP, or make the records available at Contractor's office, within 30 days of receiving the written request for the medical records.

#### (2) Method

**(a)** The DMAP Member's medical record is the basis of comparison.

**(b)** Definition of Method

**(i)** For a Validation Period, the number of Encounters observed in the medical record sampling above, but not reported by Contractor to DMAP as Encounters, is determined and computed as a percentage. This percentage is then the Contractor's Rate of Omission.

**(ii)** The Rate of Omission is extrapolated to the total number of reported Encounters to determine the total Omission Error.

**(iii)** If the Omission Error rate exceeds 10% of reported Encounters, Corrective Action may be initiated.

**b. Missing Medical Records**

**(1) Schedule**

**(a)** Missing Medical Record Errors are tabulated from the samples drawn for Omission and Accuracy Errors. DMAP, or its designee, may collect information from Contractor's DMAP Member medical records, as provided by Contractor's Provider, no less than once for each Contract Year. DMAP or its designee, shall give Contractor no less than 30 days written notice prior to reviewing or collecting information from Contractor's DMAP Member medical records. Contractor shall submit medical records to DMAP, or make the records available at Contractor's office, within 30 days of receiving the written request for the medical records.

**(b)** Upon review of the submitted medical records, DMAP staff will notify the Contractor of missing medical records. Contractor will have the opportunity to submit these missing medical records within 30 days written notice from DMAP.

**(2) Method**

**(a)** The unit of analysis is the DMAP Member's medical record.

**(b)** Definition of Method

**(i)** The number of medical records not submitted to DMAP within the 30-day period after receiving the second written notice shall be the number of Missing Medical Record Errors.

**(ii)** If medical records are missing, Corrective Action may be initiated.

**c.** Accuracy Errors

For the purpose of determining Accuracy Errors, DMAP will consider subsequent adjustments to Encounter Data, if the adjustments are made prior to the sample selection. After that time, Encounter Data will be considered final for the purpose of determining Accuracy Errors.

**(1) Schedule**

Accuracy Errors are not tabulated continuously as part of the Encounter Data system; therefore, an annual sampling of Contractor's submitted Encounter Data is required in order to assess these errors. DMAP, or its designee, may collect information from Contractor's DMAP Member medical records, as provided by Contractor's Participating Provider, to validate specific Encounter Data elements no less than once for each Contract Year. DMAP, or its designee, shall give Contractor no less than 30 days written notice prior to reviewing or collecting information from Contractor's DMAP Member medical records. Contractor shall request and submit medical records to DMAP or make the records available at Contractor's office within 30 days of receiving the written request for the medical records.

**(2) Method**

**(a)** Contractor's Accuracy Errors in the Encounter Data are computed as follows:

**(i)** The DMAP Encounter medical review team shall determine the number of errors in the test samples of Encounters that were reported to DMAP with one or more Accuracy Errors in the data elements. This determination shall be based on a comparison of information available in the medical record and the information reported to the DMAP Encounter Data system.

**(ii)** A calculated percentage of Accuracy Errors determined from the test sample shall be applied to the population of the Encounters. This number shall be reduced by a 5% error tolerance adjustment.

**(iii)** The result is the estimated number of Accuracy Error Encounters. If the Accuracy Errors exceed the 5% tolerance adjustment, Corrective Action may be initiated.

**(iv)** See Table below:

Table

Examples of recommended data quality standards for evaluation of submitted Encounter Data fields

| Data Element | Expectation | Validity Criteria |
|---|---|---|
| DMAP Member | Should be valid ID as found in the DHS eligibility or Enrollment file. | 100% valid. |
| DMAP Member Name | Should be captured in such a way that makes separating pieces of name easy. There may be some confidentiality issues that make this difficult to obtain. If collectable, expect data to be present and of good quality. | 85% present. Lengths should vary and there should be at least some last names >8 digits and some first names <8 digits. This will validate that fields have not been truncated. Also verify that a high percentage have at least a middle initial. |
| Date of Birth | Should not be missing and should be a valid date. | < 2% missing or invalid. |
| PHP ID or NPI | Critical Data Element. | 100% valid. |
| Provider NPI | Should be an enrolled Provider listed in the Provider/Capacity Report. | 95% valid. |
| Attending Provider NPI | Should be an enrolled Provider listed in the Provider/Capacity Report. | > 85% match with Provider/Capacity Report by either NPI or UPIN. |
| Provider Location | As specified in the Provider/ Capacity Report. Minimal requirement is county code, with zip code being strongly advised. | > 95% with valid county code<br>> 95% with valid zip code (if available). |
| Specialty or Taxonomy Codes | Coded mostly on physician and other practitioner, optional on other types of Providers. | Expect > 80% non-missing and valid on physician or other applicable Provider type Encounters (e.g. other practitioners). |
| Principal | Well coded except by ancillary | > 90% non-missing and valid codes (using ICD- |

| Table | | |
|---|---|---|
| Examples of recommended data quality standards for evaluation of submitted Encounter Data fields | | |
| Data Element | Expectation | Validity Criteria |
| Diagnosis | type Providers. | 9-CM lookup tables) for practitioner Providers (not including transportation, lab and other ancillary Providers). |
| Other Diagnosis | This is not expected to be coded on all Encounters even with applicable Provider types, but should be coded with a fairly high frequency. | 90% valid when present. |
| Date of Service | Dates should be evenly distributed across time. | If looking at a full year of data, 5-7% of the records should be distributed across each month. |
| Unit of Service (Quantity) | The number should be routinely coded. | 98% non-zero<br>< 70% should be one if CPT code in range 99200-99215, 99241-99291. |
| Procedure Code | This is a critical data element and should always be coded. | 99% present (not zero, blank, 8- or 9- filled). 100% should be valid, State approved codes. There should be a wide range of procedures with the same frequency as previously encountered. |
| Procedure Code Modifier | This is important to pick up to separate out surgical procedures/ anesthesia/assistant surgeon. It is not applicable for all procedure codes. | > 20% non-missing. Expect a variety of modifiers both numeric (CPT) and Alpha (HCPCS). The more common codes should appear with at least a minimal frequency are: 47 (anesthesia) and 80 (assistant surgeon). |
| Patient Discharge Status Code (Hospital) | Should be valid codes for Inpatient Encounters with the most common code to be Discharged to Home. For Outpatient Encounters it can be coded as not applicable. | For Inpatient Encounters, expect > 90% Discharged to Home. Expect 1-5% in all other values (expect non-applicable or unknown). |
| Revenue Center Code (Hospital) | Should always be present, when appropriate. | 100% valid |

**d. Inadequate Submission Errors**

**(1) S**chedule

For the purposes of validating Encounter Data for Inadequate Submission Errors, DMAP will collect and tabulate information in the DMAP Encounter Data system during the Contract Year, at DMAP's sole discretion, and without notice to Contractor.

**(2) Method**

The rate of comparison is the number of original Encounters received in DMAP's Encounter Data system as a proportion of the total Encounters.

**(a)** DMAP staff will develop submission rates for Contractor's expected rate of Encounter Data submission for each applicable Encounter type.

**(b)** Projections will consider factors including, but not limited to: Enrollment information, expected utilization of services and lag time for Contractor to receive Encounter information from Providers.

**(c)** Each month, DMAP will review the number of Encounter Data received from Contractor for each Encounter type for comparison to the expected number of Encounter Data from the Contractor for that Encounter type.

**(d)** If the number of submissions of Encounter Data received by DMAP from Contractor for any Encounter type is less than 50% of the expected number of Encounter Data for that Encounter type, Corrective Action may be initiated.

**(e)** DMAP will examine Encounter submissions, for any Encounter type, using descriptive and inferential statistics.

## 6. Corrective Action and Sanction Penalties

### a. Corrective Action

**(1)** Previous Contract requirements will be subject to Corrective Action according to the terms of that Contract Year. Termination of this Contract does not relieve Contractor of Contractor's obligation to submit all required Encounter Data for dates of service within the Contract Year, nor does it relieve Contractor of the obligation to complete Corrective Action Plans or pay recovery costs.

**(2)** When DMAP intends to implement Corrective Action the procedures stated in this subsection and in Exhibit B, Part II, Section 2, Sanctions, of this Contract shall apply.

**(3)** DMAP's contractual compliance monitoring of Contractor's Work, as it relates to this Exhibit, will occur on a daily basis. Any noncompliance issues identified by DMAP will be reported to Contractor in writing within 10 Business Days with detailed information including the area of noncompliance, severity and recommended solution(s). Contractor must respond within 10 Business Days in writing by citing Acceptable circumstances as specified in Section 1, Subsection b Paragraph (6), of this Exhibit, or proposed solutions including specific time frames for resolution.

**(4)** Noncompliance issues report by DMAP and not responded to within 10 Business Days by Contractor will be escalated to a formal Corrective Action Plan.

**(5)** A Corrective Action Plan(s) is/are developed and mutually agreed to by DMAP and Contractor. A Corrective Action Plan(s) not met by Contractor will be subject to Sanction penalties as described in Exhibit B, Part II, Section 2, Sanctions and/or this Exhibit, Section 6, Subsection b, Sanction Penalties for Pended Encounters, or both, as determined by DMAP.

**(6)** Corrective Action may be initiated if more than 10% of the Encounter Data submitted are over 180 days of the date of service or known exact duplicate Encounters exceed 10% per month.

**(7)** Contractor shall not incur additional penalties caused by errors directly related to an active Corrective Action Plan if the matter is resolved within a mutually agreed upon time frame. DMAP will initiate a revised Corrective Action Plan if new errors not directly related to the current Corrective Action Plan occur.

**b. Sanction Penalties for Pended Encounters**

**(1)** Failure to comply with a Corrective Action Plan related to the requirements of data submissions as described in Exhibit B, Part V, Section 3, Encounter and Pharmacy Data and this Exhibit, Sections 3 and 4 shall be subject to sanctions imposed at DMAP's sole discretion and as specified in Subsection b, of this section, Paragraph (3), Sanctions Penalty Table for Pended Encounters.

**(2)** Sanction penalties imposed by DMAP for Pended Claims not corrected within 63 days as described in Section 3 and 4 shall be calculated based on the Sanction Penalty Table below. For penalty levels of 1% of Monthly Capitation refer to Exhibit B, Part VI, Section 2, Sanctions, Subsection b (2).

**(3)** Sanction Penalty Table for Pended Encounters

**(a)** Capacity is the average of the Contractual Enrollment Limit for the 12 month period preceding the month a Sanction will be applied based on Contractor's Enrollment Limits established in Contract to provide Covered Services in a specific Service Area(s) as indicated in Part V, Enrollment Limits, of this Contract.

**(b)** The Pended Encounter penalty is calculated by dividing the number of Pended Encounters, as identified by DMAP, by Contractor's Capacity. The resulting ratio of Pended Encounters to Capacity is the percentage value that is used to determine the financial penalty due to DMAP from Contractor, unless a Pended Encounter penalty has been levied within the last two consecutive Contract years. If so, the sanction amounts are then multiplied by the number of times DMAP or Contractor initiated a Pended Encounter penalty during the last two consecutive Contract Years. Encounter sanction penalties will not exceed 1% of Contractor's Monthly Capitation Payment.

**Penalty Table for Pended Encounters**

| **Percent of Encounters Pended** | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| 100 Encounters or Less (or less than 1%) | 1.0% - 1.9% | 2.0%-4.9% | 5%-9.9% | 10%-19.9% | 20%-29.9% | 30%-39.9% | 40% or higher |
| Zero dollars | $5,000 | $10,000 | $15,000 | $20,000 | $25,000 | $30,000 | $35,000 or 1% of Monthly Capitation (unless the 1% is the lesser of the two) |

Percentages are rounded up to the nearest tenth of a percent.

## EXHIBIT H – Attachment 1 - Data Certification and Validation

### Instructions H.1 - Encounter Data or Pharmacy Transaction Submission

**1.** Contractor shall demonstrate to DMAP through proof of Data Certification and Validation that Contractor is able to attest to the accuracy, completeness and truthfulness of Information required by DMAP. The requirements in this Exhibit H are intended to implement the requirements of 42 CFR §§ 438.604 and 438.606.

The Data and Information that must be certified include, but are not limited to, Encounter Data and Pharmacy Transactions. Contractor shall submit to DMAP all reports specified in this Contract and this Exhibit.

**2.** Required Data Certification and Validation Report Forms

Contractor shall submit the report forms listed below to DMAP in the manner described in this Contract and on each form or report.

H.1 Signature Authorization Form
H.2 Data Certification and Validation Report Form
H.3 Claim Count Verification Acknowledgement and Action Form

Form H.2 – A Data Certification and Validation Report Form must be submitted concurrently with each Encounter Data or Pharmacy Transaction submission. DMAP will notify Contractor if Form H.2 does not meet the requirements.

Contractor shall submit missing or erroneous Form H.2 Data Certification and Validation Reports immediately upon notification from DMAP that the Data Certification and Validation Report Form was not complete or not received.

Submission of each complete and accurate Data Certification and Validation Report Form is a material requirement of this Exhibit and this Contract, as specified in 42 CFR §§ 438.604 and 438.606. Contractor non-compliance as specified above will be considered a breach of Contract and subject to sanctions as described in this Contract.

After MMIS processing, DMAP will return the following reports, as applicable, to provide detail information identifying any Claim counts out of balance and Claim counts that will not be used for Rate or Risk Calculations:
Data Validation – Claim Count Verification Form

Data Validation – Weekly Balancing
Data Validation – Cumulative Pends
Data Validation – Duplicate Check Criteria
Data Validation – OMART (data system maintained by DMAP)

## EXHIBIT H – Attachment 2 - Form H.2 – Signature Authorization Form

Contracted Plan
Name _____ DMAP Assigned Plan Number: _____

Encounter Data and Pharmacy Transaction information submitted to DMAP must be certified by one of the following:

Chief Executive Officer (CEO),
Chief Financial Officer (CFO), or
An individual who has delegated authority to sign for and reports directly to the CEO or CFO.

_____ _____
Print name and title of CEO/CFO Signature

_____
Date

As CEO/CFO I authorize the following designated person(s) to certify Encounter Data and/or Pharmacy Transactions:

Full name and title of the person(s) other than the CEO or CFO identified above who has delegated authority to sign for and who reports directly to the CEO or CFO, and to certify the data and information submitted to DMAP:

_____ _____
Print Name and Title Print Name and Title

_____ _____
Signature Date Signature Date

_____ _____
Telephone number Telephone number

(Submit more than one form if more than two persons are delegated to complete the Data Certification and Validation Report Form)

Content and Timing of Certification: The Data Certification and Validation Form must attest, based on best knowledge, information and belief, as follows:

**1.** To the accuracy, completeness and truthfulness of the data and/or information submitted to DMAP,
**2.** To the accuracy, completeness and truthfulness of the information contained in the Form H.2, Data Certification and Validation Report Form and
**3.** The Data Certification and Validation Report Form must be submitted concurrently with Contractor's certified data.

Send this complete, original Signature Authorization Form to your Encounter Data Liaison. Contractor must complete a new Signature Authorization Form immediately each time there is a change to any one of the designated certifying person(s).

**EXHIBIT H – Attachment 3 - Form H.3 – Data Certification and Validation Report Form***

**This form must be submitted concurrently with each Encounter Data or Pharmacy Transaction submission, if by facsimile to phone number 503-947-5359. If you experience any difficulty faxing this form to the number indicated contact your Encounter Data Liaison.**

Plan Name: _____ Plan DMAP Number: _____

Week Ending: _____ Type of submission: _____
Month/Day/Year Encounter/Pharmacy

| | | | |
|---|---|---|---|
| Total Claim Count** | | Total Billed Amount ** | $ |

I, the undersigned, hereby attest that I have authority to certify the data and information on behalf of Contractor, as authorized by Form H.1, Signature Authorization Form; and I, the undersigned, hereby certify based on best knowledge, information and belief that the data and information submitted to DMAP are accurate, complete and truthful; and that the data and information contained in this Form H.2, Data Certification and Validation Form, are accurate, complete and truthful.

_____
Print Name Print Title

_____
Authorized signature (from Form H.1) Transmission Date

Contractor may, at Contractor's discretion, submit more detailed submission totals than the minimum necessary required above. To do so contact your designated Encounter Data Liaison.

* If you have the ability to send an "electronic signature document" please contact your Encounter Data Liaison
** Total Claim Count and Total Amount Billed includes all Claims sent to DMAP for processing (new, adjustments or deletes)

## EXHIBIT H – Attachment 4 - Form H.4 – Claim Count Verification Acknowledgement and Action Form

Contractor shall complete this Acknowledgement and Action Form and return it Contractor's designated Encounter Data Liaison within ten (10) Business Days of receipt of the Out of Balance Data Validation–Claim Count Verification Report notice.

For week ending date: _____ the following explanation is given for DMAP identified out of balances.

Include any action Contractor will take to adjust or resolve the out of balance.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

I, the undersigned, hereby attest that a copy of this Form H.3, Claim Count Verification Acknowledgment and Action Form has been provided to the Chief Executive Officer, Chief Financial Officer, or the individual who has delegated authority to certify data by Form H.1, Signature Authorization Form.

_____ _____
Print Name Print Title

_____ _____
Signature Date

## EXHIBIT I – Third Party Resources and Personal Injury Liens

**1.** Contractor shall take all reasonable actions to pursue recovery of Third Party Resources for Capitated Services provided during the Contract Year. "Third Party Resources" 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 DMAP Member. Third Party Resources include but are not limited to:

**a.** Private health insurance;

**b.** Employment-related health insurance;

**c.** Medical support from absent parents;

**d.** Automobile insurance;

**e.** Workers' compensation;

**f.** Medicare; and

**g.** Other federal programs, unless excluded by statute as, for example:

**(1)** Services provided to DMAP Members pursuant to 42 CFR 36.61 Indian Health Service (IHS) is the payor of last resort and is not considered a Third Party Resource; or

**(2)** Services provided to DMAP Members at a tribal facility operated under a "638" agreement pursuant to the Memorandum of Agreement between HIS and CMS (see Native American Services Provider Guide) is a payor of last resort and is not considered a Third Party Resource.

**h.** Claims, judgments, settlements or compromises in relation to personal injuries where the Covered Services paid by Contractor constitute assistance, as these terms are defined in ORS 416.510.

**2.** Contractor will develop and implement written policies describing its procedures for Third Party Resource recovery. DMAP may review Contractor's policies and procedures for compliance with this Contract and, to the extent DMAP determines applicable, for consistency with Third Party Resource recovery requirements in 42 USC 1396a(a)(25) and 42 CFR 433 Subpart D. At a minimum, the policies and procedures shall include the following information.

**a.** Describe Contractor's procedures for identifying Third Party Resource.

**(1)** Contractor shall notify the Health Insurance Group, P.O. Box 14023, Salem, Oregon 97309, within thirty (30) days from the time that Contractor learns that a DMAP Member might have other health insurance. Any Contractor that also provides or has an affiliate that provides commercial insurance shall have a systematic process for identifying DMAP Members with dual or overlapping coverage with Contractor and shall notify the Health Insurance Group or DMAP at the Department of Human Services, 500 Summer St. NE, E44, Salem, Oregon

97310 Attention: HMU, within fifteen (15) Business Days of the time such a DMAP Member is identified. The notification to DMAP will include the DMAP Member's name, Social Security Number, State Medical Identification, the name of the policy holder, the name and address of the insurance company, the group and/or policy number, and any other identifying information available to the Contractor, such as dates of coverage, etc.

**(2)** Contractor shall immediately report that a DMAP Member has a potential third party claim for personal injuries, or has made a claim or begun an action to enforce such claim, as those terms are defined in ORS 416.510, to the DMAP Member's caseworker and the DHS's Personal Injury Liens Unit, P.O. Box 14512, Salem, OR 97309-0416.

**(3)** To the extent authorized by law, DHS will share client and Claim information they receive with Contractor to assist in identifying Third Party Resources.

**b.** Describe Contractor's procedures for determining the liability of Third Party Resource.

**(1)** Contractor shall require DMAP Members to cooperate in securing payment from Third Party Resources, except when the DMAP Member asserts good cause as defined in OAR 461-120-0350. Contractor may not require DMAP Members to file a claim other than for Personal Injury Protection coverage.

**(2)** If Contractor is unable to gain cooperation from the DMAP Member or their authorized Representative or a Third Party Resource in pursuing the Third Party Resource, or if the DMAP Member or their Representative asserts good cause, Contractor shall notify the Medical Payment Recovery Unit, P.O. Box 14023, Salem Oregon 97309, of their refusal to cooperate, and provide such records and documentation as may be requested from the Medical Payment Recovery Unit.

**c.** Describe the circumstances in which Contractor will apply "Cost-avoidance" to Third Party Resources.

**(1)** "Cost-avoidance" is defined as a method for avoiding payment of Medicaid Claims when Medicare or other insurance resources are available to the DMAP Member. Using this method, whenever Contractor is billed first, Claims are denied and returned to the Provider who is instructed to bill and collect from liable Third Party Resources. Cost-avoidance also includes payment avoided when the Provider bills the Third Party Resource first.

**(2)** Contractor may not refuse payment for Covered Services based solely on a diagnosis code if there is no documentation of a potential Third Party Resource other than the diagnosis.

**(3)** Contractor may not delay payment after a Provider notifies Contractor that the Provider cannot obtain recovery from a Third Party Resource after making reasonable efforts, or cannot obtain information or cooperation needed from the DMAP Member or a Third Party Resource to obtain recovery from a Third Party Resource. Upon notification, Contractor shall process the Claim as a Valid Claim consistent with Exhibit B, Part IV, Section 3 of this Contract. Contractor may

pursue alternative remedies or may seek to recover payment as outlined in this Exhibit.

**d.** Describe the circumstances in which Contractor will "Pay and Chase" Third Party Resources. "Pay and Chase" is defined as a method used where Contractor pays the recipient's medical bills and then attempts to recover from liable Third Party Resources. "Pay and Chase" is mandatory whenever the following conditions exist:

**(1)** Contractor must Pay and Chase in situations where the Claim is for prenatal care (including labor and delivery and post-partum care) for pregnant women or preventive pediatric services that are Covered Services, although Contractor may cost-avoid Claims associated with the Inpatient hospital stay for labor and delivery and post-partum care.

**(2)** Contractor shall Pay and Chase for prescription drug payments, subject to initial offset for known coordination of benefits in Contractor's pharmacy payment system.

**e.** Describe the procedures for identifying and requesting payment from a Third Party Resource that applies to personal injury.

**(1)** Contractor's recourse for obtaining an assignment of lien rights shall be the process provided in ORS 416.510 to 416.610 and OAR 461-195-0301 to 461-195-0350. Contractor shall not request an assignment of right to recovery or assignment of a lien right from a DMAP Member or their Representative.

**(2)** When another party may be liable for a personal injury, Contractor may make the payments and (consistent with Subsection (1) of this Section e) place a lien against a judgment, settlement or compromise. Once Contractor has made the payment for Covered Services and a lien has been sought, no additional billing or Claim for enhanced reimbursement (e.g., balance billing) to the third party or to the DMAP Member or their finally responsible Representative is permitted.

**f.** Contractor shall maintain records of Contractor's actions and Subcontractors' actions related to Third Party Resource recovery, and make those records available for DMAP review.

**(1)** Contractor shall report all Third Party Resource payments to DMAP on the OHP Coordination of Benefits and Subrogation Recovery Section on the Quarterly Report, Report G.8 of Exhibit G.

**(2)** Contractor shall maintain records of Third Party Resource 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.

**(3)** Contractor shall provide documentation about personal injury recovery actions and documentation about personal injury liens to the DHS's Personal Injury Liens Unit consistent with OAR 461-195-0301 to 461-195-0350.

**3.** Contractor may not refuse to provide Covered Services, and shall require that its Subcontractors may not refuse to provide Covered Services, to an DMAP Member because of a Third Party Resource's potential liability for payment for the Covered Service.

**4.** Contractor is the payer of last resort when there is other insurance or Medicare in effect. At DMAP's discretion or at the request of the Contractor, DMAP may retroactively Disenroll a DMAP Member to the time the DMAP Member acquired Third Party Resource insurance, pursuant to OAR 410-141-0080(2)(b)(D) or 410-141-0080(3)(a)(A), based on DMAP's determination that services may be provided cost effectively on a fee-for-service basis. When a DMAP Member is retroactively Disenrolled under this section of this Contract, DMAP 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 DMAP Member (or any financially responsible Representative of the DMAP Member) or any Third Party Resource, any amounts paid for any Covered Services provided on or after the date of Disenrollment.

**5.** 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.

**a.** Where Medicare and Contractor have paid for services, and the amount available from the Third Party Resource is not sufficient to satisfy the Claims of both programs to reimbursement, the Third Party Resource must reimburse Medicare the full amount of its Claim before any other entity, including Contractor or its Subcontractor, may be paid.

**b.** If the Third Party Resource has reimbursed Contractor or its Subcontractor, or if a DMAP Member, after receiving payment from the Third Party Resource, has reimbursed Contractor or its Subcontractor, the Contractor or its Subcontractor must reimburse Medicare up to the full amount the Contractor/Subcontractor received, if Medicare is unable to recover its payment from the remainder of the Third Party Resource payment.

**c.** 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 DMAP, described in Section 2, Subsection e, of this Exhibit I.

**6.** When engaging in Third Party Resource 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. DMAP considers the disclosure of DMAP 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.

## EXHIBIT J - Prevention and Detection of Fraud and Abuse

### 1. Prevention/Detection of Fraud and Abuse

**a.** Contractor shall have in place fraud and abuse policies, which enable the Contractor to prevent and detect fraud and abuse activities as such activities relate to the OHP. This may include operational policies and controls in areas such as Claims, prior authorization, utilization management and quality review, DMAP Member Complaint and Appeal resolution, Participating Provider credentialing and contracting, Participating Provider and staff education, and Corrective Action Plans to prevent potential fraud and abuse activities.

**b.** Contractor shall review its fraud and abuse policies annually. If the Contractor has updated the current policies, a written copy of the updated fraud and abuse policies must be submitted by March 15th of the Contract Year, to Department of Human Services, Division of Medical Assistance Programs, Medical Section, Quality Assurance and Improvement Unit.

**c.** At a minimum fraud and abuse policies should include the following twelve elements:

**(1)** The development and distribution to Contractor's employees and Subcontractors, of written standards of conduct, as well as written policies and procedures that:

**(a)** Require the Contractor's commitment to compliance;

**(b)** Address specific areas of potential fraud, such as Claims submission process, and financial relationships with its Subcontractors;

**(c)** Provide detailed information about the False Claims Act established under Sections 3729 through 3733 of title 31, United States Code, administrative remedies for false Claims and statements established under chapter 38 of title 31, United States Code, any Oregon laws pertaining to civil or criminal penalties for false Claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs (as defined in 42 USC 1320a-7b. Such Oregon laws shall include the following:

ORS 411.670 to 411.690 (submitting wrongful Claim or payment prohibited; liability of person wrongfully receiving payment; amount of recovery); ORS 646.505 to 646.656 (unlawful trade practices); ORS chapter 162 (crimes related to perjury, false swearing and unsworn falsification); ORS chapter 164 (crimes related to theft); ORS chapter 165 (crimes involving fraud or deception), including but not limited to ORS 165.080 (falsification of business records) and ORS 165.690 to 165.698 (false Claims for health care payments); ORS 166.715 to 166.735 (racketeering – civil or criminal); ORS 659A.200 to 659A.224 (whistleblowing); ORS 659A.230 to 659A.233 (whistleblowing); OAR

410-120-1395 to 410-120-1510 (program integrity, sanctions, fraud and abuse); and common law claims founded in fraud, including Fraud, Money Paid by Mistake and Money Paid by False Pretenses.

Contractor understands that this description of the laws that must be included in the employee handbook under this section of this Contract does not limit the authority of DMAP or any health oversight agency or law enforcement entity from fully exercising its legal authority or from pursuing legal recourse to the full extent of the law.

**(d)** Provide as part of the written policies, detailed provisions regarding the Contractor's policies and procedures for detecting and preventing fraud, waste and abuse; and

**(e)** Include in any employee handbook for the Contractor, a specific discussion of the laws described in Item (c ) of this paragraph, the rights of employees to be protected as whistleblowers, and the Contractor's policies and procedures for detecting and preventing fraud, waste and abuse.

**(2)** The designation of a chief compliance officer and other appropriate bodies charged with the responsibility of operating and monitoring the fraud and abuse program and who report directly to the CEO and the governing body;

**(3)** The development and implementation of regular, effective education and training programs for all affected employees and Subcontractors;

**(4)** The creation and maintenance of a process to receive Complaints and the adoption of procedures to protect the anonymity of complainants and to protect callers from retaliation;

**(5)** The development of a system to respond to allegations of improper/illegal activities and the enforcement of appropriate disciplinary action against employees or Subcontractors, who have violated internal fraud and abuse policies, applicable statutes, regulations, Federal or State health care program requirements;

**(6)** The use of risk evaluation techniques to monitor compliance and assist in the reduction of identified problem areas;

**(7)** The investigation and correction of identified systemic problems and the development of policies addressing the non-employment of sanctioned individuals by Contractor and its Subcontractors;

**(8)** The referral process required under Subsection e., of this section;

**(9)** Enforcement of standards through well-publicized disciplinary guidelines;

**(10)** Provision for internal monitoring and auditing;

**(11)** Provision for prompt response to detected offenses, and for development of Corrective Action initiatives relating to the Contractor's contract; and

**(12)** Effective lines of communication between the DHS's compliance office and Contractor's employees.

**d. Participation of Suspended or Terminated Providers**

**(1)** The Covered Services provided by the Contractor pursuant to Contract may not be provided by the following persons (or their affiliates as defined in the Federal Acquisition Regulations):

**(a)** Persons or entities who are currently suspended, debarred or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issues pursuant to Executive Order No. 12549 or under guidelines implementing such order;

**(b)** Persons or entities who are currently suspended or terminated from the Oregon Medical Assistance Program or excluded from participation in the Medicare program; or

**(c)** Persons who have been convicted of a felony or misdemeanor related to a crime or violation of Title XVIII, XIX or XX of the Social Security Act and/or related laws (or entered a plea of nolo contendere).

**(i)** Contractor shall not refer DMAP Members to such persons and shall not accept billings for services to DMAP Members submitted by such persons.

**(ii)** Contractor may not knowingly:

**(A)** Have a person described in Item (a) of this Paragraph (1) as a director, officer, partner, or person with beneficial ownership of more than 5 percent of Contractor's equity; or

**(B)** Have an employment, consulting, or other agreement with a person described in Item (a) of this Paragraph (1) for the provision of items and services that are significant and material to the Contractor's obligations under Service Agreement.

**(2)** Contractor shall not pay Providers who are suspended, terminated or excluded by Medicare, Medicaid, or SCHIP under Paragraph (1), of this Subsection d, except for Emergency Services. If Contractor makes any unauthorized payments to any excluded Providers, Contractor shall recover those payments from the Provider.

**e. Referral Policy**

**(1)** Contractor is required to 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)** 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/her compliance rating and/or collecting Medicaid payments otherwise not due. This would include 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 DMAP 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 DMAP Members under their Subcontracts with the Contractor and under OHP regulations;

**(viii)** Providers who knowingly charge DMAP Members for services that are Covered Services or intentionally balance-bill a DMAP Member the difference between the total fee-for-service charge and Contractor's payment to the Provider, in violation of DMAP rules;

**(ix)** Any suspected case where the Provider intentionally submitted a Claim for payment that already has been paid by DMAP 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 DMAP 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 DMAP Member's decision to exercise his or her right to refuse Medically Appropriate care, or because the DMAP 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).

**f. When to Report Fraud and Abuse**

**(1)** An incident with any of the referral characteristics listed in Subsection e, of this section must be reported to the MFCU, and any other incident found to have characteristics which indicate fraud or abuse which Contractor has verified should also be reported. Reports to the MFCU shall include:

**(a)** Contractor name, contact person and phone number; and

**(b)** Number of complaints of fraud and abuse that warrant investigation. For each which warrants investigation Contractor shall include:

**(i)** Provider's name and Provider's phone number;

**(ii)** The source of the complaint;

**(iii)** The type of Provider;

**(iv)** The nature of the complaint;

**(v)** The approximate range of dollars involved; and

**(vi)** The legal and administrative disposition of the case, including actions taken by law enforcement officials to whom the case has been referred.

Contractor may also refer cases of suspected fraud and abuse to the MFCU or to the Department of Human Services Audit Unit, or both, prior to verification.

**(2)** 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.

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

The Department of Justice Medicaid Fraud Control Unit (MFCU) phone number is (503) 229-5725, address 1515 SW 5th Avenue, Suite 410, Portland, Oregon 97201, and fax is (503) 229-5459. The Department of Human Services Audit Unit phone number is (503) 945-6691, address 500 Summer St. NE, Salem, Oregon 97310-1097, and fax is (503) 945-7029.

**h. Obligations to Assist the MFCU and DHS**

**(1)** Contractor shall promptly report all suspected fraud and abuse as required under this Exhibit J.

**(2)** Contractor shall permit the MFCU or DHS 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.

**(3)** Contractor shall cooperate and require its Subcontractors to cooperate with the MFCU and DHS investigator during any investigation of fraud or abuse.

**(4)** In the event that Contractor reports suspected fraud, or learns of an MFCU or DHS investigation, it should not notify or otherwise advise its Subcontractors of the investigation. Doing so may compromise the investigation.

**(5)** 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 DHS during an investigation.

**i. Prevention and Detection of Member Fraud and Abuse**

Contractor, if made aware of suspected fraud or abuse by a DMAP Member, (i.e. a Provider reporting DMAP Member fraud and abuse) shall report the incident to the DHS Fraud Unit. Address suspected DMAP 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.

# EXHIBIT K – Provider Capacity Report

## 1. Requirements:

Contractor shall submit a Certified Provider Capacity Report and a Publicly Funded Program Involvement Status Report to the Division of Medical Assistance Programs (DMAP) with specific information about each of Contractor's Providers.

The Provider Capacity Report shall include data for each variable name appearing on the table below. To be in compliance with this requirement and that of Exhibit M, Contractor shall not omit the required information from the table below for any Participating Provider on the Provider panel. Providers include physicians (Primary Care Physicians (PCP) and specialists), dentists, hospitals, hospices, laboratories, Extended Care Facilities, DME Participating Providers, County Health Programs, Rural Health Centers, Federally Qualified Health Centers and any other Participating Provider, as defined in this Contract, with which Contractor has a subcontract. If a Participating Provider has more than one practice address, submit a separate record for each practice address of the Participating Provider.

For the purposes of this Exhibit related to Credential Verification (Data Element #15 listed in the table below) Contractor shall refer to Exhibit B, Part II, Section 4 and OAR 410-141-0120, pursuant to 42CFR438.214.

## 2. Filing Requirements:

Contractor shall submit to DMAP a Certified Provider Capacity Report containing information about each Provider on their Provider panel as of January 1st (submit reports to DMAP by March 31st) of each year that this Contract is in effect. Contractor shall submit supplemental reports as directed by DMAP any time there has been a Material Change in Contractor's operations that would affect capacity or services, including (1) changes in services, benefits, service area or payments or (2) enrollment of a new population to Contractor. Contractor shall submit supplemental reports during the year, if requested by DMAP.

Contractor shall submit Form L.1, certifying to the accuracy, completeness, and truthfulness of the information in the Provider Capacity Report, by fax to the number below.

Contractor shall submit to DMAP the Provider Capacity Report in an electronic format which has been approved by DMAP via e-mail by contacting your designated PHP Coordinator (PHPC) or designee or by mailing a disk or compact disk (CD) containing the required information, as specified in Section 3, of this Exhibit, to the following address:

Prepaid Health Plan Coordinator
Division of Medical Assistance Programs
Delivery Systems Unit
500 Summer Street NE, E-35
Salem, OR 97301-1077
Fax: (503) 947-5221

A Provider Capacity Report that is not certified or that does not contain all of the data elements specified in Section 3, of this Exhibit shall not be accepted by DMAP, and Contractor must submit a corrected Provider Capacity Report as directed by DMAP's designated PHPC or designee.

DMAP will review the Provider Capacity Report and communicate preliminary findings to Contractor within 30 Business Days of receipt. If errors or omissions are found DMAP will communicate detailed findings including expected resolution timelines for the Contractor within 60 Business Days of receipt. Contractor will have 30 Business Days from the date of notice to correct errors or omissions and re-submit the report. Failure to submit the required report or correct errors or omissions may result in sanctions, per contract.

**3. Format**:

Contractor shall submit the Provider Capacity Report to DMAP in the electronic format of Microsoft Excel. The field types and sizes are required and may be submitted in an alternate format if Contractor obtains prior approval from DMAP by contacting Contractor's PHPC or designee.

**Required Data Elements**

| LINE | VARIABLE NAME | TYPE | SIZE | SPECIAL INSTRUCTIONS |
|---|---|---|---|---|
| 1 | CONTRACTOR NAME | A | 50 | The name of the Contractor that this Provider Capacity Report pertains to and is submitted by. |
| 2 | LAST NAME | A | 50 | Last name of the Provider.<br>If the Provider has practices in multiple areas, complete a record line for each practice location. |
| 3 | FIRST NAME | A | 25 | First name of the Provider. |
| 4 | BUSINESS/PRACTICE ADDRESS | A/N | 50 | Address of the Provider's practice, including suite number. If the Provider does not have a practice address, list the business address. (i.e. lab/ diagnostic companies) |
| 5 | BUSINESS/PRACTICE CITY | A | 20 | City where the Provider's business is located. |
| 6 | BUSINESS/PRACTICE ZIP CODE | N | 10 | Formatted zip code - (9999) four digit code (i.e. 97214-1014) |
| 7 | BUSINESS COUNTY | A | 15 | The county in which the Provider's business is located. |
| 8 | PROVIDER TYPE | A | 5 | Table 1 in Section 6 of this Exhibit K must be used. |
| 9 | SPECIALTY | A | 15 | Table 2 in Section 6 of Exhibit K must be used. If a specialty code does not apply, please use "not applicable". |
| 10 | PROVIDER'S DMAP NUMBER | A/N | 6 | DMAP assigned Provider number as supplied with Encounter Data. "999999" can be used if the Provider is not a PCP or the number is not known. |
| 11 | OTHER PROVIDER # | A/N | 13 | UPIN; The Provider's unique Provider identification number or (NPI). (Required only if 11, above, is "999999") |
| 12 | PRIMARY CARE PROVIDER (PCP) IDENTIFIER | A | 1 | Y = This Provider is a PCP.<br>N = This Provider is not a PCP.<br>DMAP |

| LINE | VARIABLE NAME | TYPE | SIZE | SPECIAL INSTRUCTIONS |
|---|---|---|---|---|
| 13 | # MEMBERS ASSIGNED | N | 4 | Number of Contractor's DMAP Members currently assigned to this PCP or clinic. |
| 14 | # OF ADDITIONAL MEMBERS THAT CAN BE ASSIGNED TO PCP | N | 5 | Estimated number of additional members PCP will accept.<br>If #12 = N, answer "0" |
| 15 | CREDENTIAL VERFICATION | N | 8 | Date Contractor verified or certified Provider's credentials (mm/dd/yy) as required in OAR 410-141-0120(1)(a). |
| 16 | SANCTION HISTORY | A/N | 50 | Brief description of any sanctions, fines or disciplinary actions that are currently active from the appropriate licensing board(s), DHS including DMAP, AMH, and SPD, DHS audit unit, Oregon Medicaid Fraud Unit, Oregon Secretary of State, Oregon Insurance Division, Oregon Department of Justice, U.S. Attorney or Department of Justice, CMS, or DHHS Office of Inspector General. If this is not applicable, answer "not applicable". |
| 17 | CONTRACT START DATE | A/N | 25 | mm/dd/yy Include a copy of new subcontracts since last report as required in Exhibit D, Section 16 and 42 CFR 438.230. |
| 18 | CONTRACT END DATE | A/N | 25 | mm/dd/yy. If contract is open-ended, answer 99/99/99 for end date. |

**4. Capacity by Service Area**

**a.** Service Area as designated in this Contract Part V, Enrollment Limits – the individual Service Areas listed in this Contract.

**b.** Total number of Primary Care Providers – the number of PCPs on panel for the designated service area.

**c.** Total number of DMAP Members served – the unduplicated count of enrolled members receiving service in the preceding 12-month period. A service must qualify as an "Encounter" as defined in Exhibit H.

| (1) DMAP Service Area as designated in Part V Enrollment Limits | (2) Total number of Primary Care Providers | (3) Total number DMAP Members served |
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**Add lines as necessary for each Service Area.**

## 5. Publicly Funded Program Involvement Status Report:

The following table details Contractor's involvement with publicly funded health care and service programs. Include those publicly funded health care and service programs with which Contractor has subcontracts.

| Name of publicly funded program | Type of public program (i.e. county mental health dept.) | County in which program provides services | Description of the services provided in relation to Contractor's services | What has been the involvement of the public program in Contractor's operations (on the board, on Quality Assurance Committee, specify if subcontract, etc.)? |
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## 6. Provider Type and Provider Specialty Code Listing:

Two tables are found below: 1) the Provider/ Type code table and 2) Provider specialty code table. Use these codes to specify the required information on Contractor's Provider Capacity Report file as outlined in Section 3, Required Data Elements, line number 9 of this Exhibit.

**Provider Type Code Table 1**

| Provider Type Code | Provider Type | Provider Type Code | Provider Type |
|---|---|---|---|
| AA | Air Ambulance | NF | SNF/ICF |
| AC | Alcohol and Drug | NM | Midwives, direct entry |
| AD | Adult Day Health | NP | Nurse Practitioner |
| AF | Adult Foster Care | NT | Nutritionist under MCM |
| AM | Ambulance | OD | Optometrist |
| AS | Ambulatory Surgical | OP | Optician, dispensing |
| AT | Medical Air Transport | OT | Occupational Therapist |
| BC | Birthing Center | PB | Public Clinic |
| BP | Billing Provider | PH | Pharmacy |
| BR | Transportation Broker | PR | Pre-natal Clinic |
| CD | Contract Dentist | PS | Psychiatrist |
| CK | Medicheck Screening Center | PT | Physical Therapist |
| CR | Rural Health Clinic | PX | X-ray service |
| DC | Chiropractor | PY | Psychologist |
| DM | Dentist | RA | Personal Care RN |
| DO | Medical Doctor, Osteopath | RC | Residential Care Medical |

| | | | |
|---|---|---|---|
| DS | Podiatrist | RF | Residential Care |
| DT | Denturist | RH | Residential Care - HA |
| FC | Family Planning Clinic | RM | Residential Care - MR |
| FQ | FQHC | RN | Private Duty Nurse |
| HE | Hearing Aid Dealer | RT | Residential Treatment - Med |
| HF | Hemodialysis Facility | SC | Social Worker |
| HH | Home Health | SE | Secured Transportation |
| HI | HMO | SH | Audiologist/Speech Therapist |
| HK | Homecare | SL | Specialized Living Facility |
| HO | Hospital | SM | School Medical |
| HP | Hospice | SR | Satellite Apartment-Medical |
| IA | In Home Agency Provider | SS | Nursing Home Semi-Skilled |
| IH | Indian Health Clinic | TA | Taxi |
| IL | Independent Laboratory | TC | Targeted Case Management |
| KD | Kidney Dialysis | WC | Wheelchair |
| LF | Assisted Living Facility | | |
| MC | MHO – AMH Provider | | |
| MD | Physician | | |
| MH | Mental Health | | |
| MM | Miscellaneous Medical Svcs. | | |
| MS | ICF/MR | | |
| NA | Nurse Anesthetist | | |
| ND | Naturopath | | |

**Provider Specialty/Sub-Specialty Code Table 2**

Use the codes on the following page to specify the required information on Contractor's Provider Capacity Report file as outlined in Section 3, Required Data Elements, line number 10 of this Exhibit.

| Specialty/ Sub-specialty | Code | Specialty/ Sub-specialty | Code |
|---|---|---|---|
| Allergy | AA | Neuropathology | NA |
| Abdominal Surgery | AB | Neoplastic Diseases | ND |
| Audiologist | AD | Neurology | NE |
| Adolescent | AE | Nephrology | NF |
| Allergy and Immunology | AL | Pharmacy Dispensing to Nursing Home | NH |
| Aviation Medicine | AM | Nuclear Medicine | NM |
| Anesthesiology | AN | Neonatal-Perinatal Medicine | NP |
| Bacteriology | BA | Nuclear Radiology | NR |
| Broncho-Esophagology | BE | Neurological Surgery | NS |
| Blood banking | BL | Nutrition | NT |
| Billing Service Nonpayable | BS | Ophthalmology | OA |
| Cardiology | CA | Obstetrics | OB |
| Clearinghouse Nonpayable | CB | Orthodontist | OD |
| Congregate Care | CC | Other Entity Nonpayable | OE |
| Cardiovascular Diseases | CD | Obstetrics & Gynecology | OG |
| Child Psychiatry | CH | Oral Surgery | OL |
| Child Neurology | CI | Occupational Medicine | OM |
| Federal Qualified Health Center | CL | Oncology | ON |

| | | | |
|---|---|---|---|
| Critical Care Medicine | CM | Oral Pathology | OP |
| Clinical Pathology | CP | Orthopedic Surgery | OR |
| Colon & Rectal Surgery | CR | Oral Surgeon | OS |
| Cardiovascular Surgery | CS | Otology, Laryngology, Rhino | OT |
| Dermatology | DE | Otology | OU |
| Diabetes | DI | Oxygen Supplies | OX |
| Misc Med Equip/ Supplies | DM | Pathology | PA |
| DME for Pharmacy | DN | Prosthodontics | PC |
| Osteopathic Physician | DO | Pediatrics | PD |
| Dermatopathology | DP | Periodontist | PE |
| Diagnostic Radiology | DR | Pediatric Allergy | PF |
| Endocrinology | ED | Pediatric Cardiology | PG |
| Emergency Medicine | EM | Public Health | PH |
| Endodontist | EN | Pediatric Endocrinology | PI |
| Forensic Pathology | FO | Pediatric Radiology | PJ |
| Family Practice | FP | Pediatric Surgery | PK |
| Gastroenterology | GD | Plastic Surgery | PL |
| Geriatrics | GE | Physical Medicine & Rehab | PM |
| General Dentist | GN | Psychiatry, Neurology | PN |
| General Practice | GP | Pediatric Hemotology-Onco | PO |
| Gynecology | GY | Pediatric Nephrology | PP |
| Hospital Administration | HA | Proctology | PR |
| Hospital Based Clinic (PCCM) | HC | Psychiatry | PS |
| Hearing Aids Dealer | HE | Pediodontist | PT |
| Hematology | HM | Pulmonary Diseases | PU |
| Head & Neck Surgery | HN | Preventive Medicine | PV |
| Hand Surgery | HS | Psychoanalysis | PW |
| House Calls, Inc Physician | HV | Psychosomatic Medicine | PX |
| Hypnosis | HY | Pharmacology | PY |
| Infectious Diseases | ID | Rheumatology | RE |
| Immunology | IG | Rhinology | RH |
| Internal Medicine | IM | Radioisotopic Pathology | RI |
| Intensive Outpatient Services | IO | Radiology | RR |
| Industrial Medicine | IP | Speech Therapist | ST |
| Kidney Dialysis Facility | KD | General Surgeon | SU |
| Laryngology | LA | Therapeutic Radiology | TR |
| Legal Medicine | LM | Thoracic Surgery | TS |
| Maxillofacial Surgery | MF | Traumatic Surgery | TU |
| Enteral/ Parenteral for HH, MM, PH, RN | MM | UOHSC Practitioners | UO |
| Medicheck Screen Clinic | MS | Urology | UR |
| Manipulative Therapy | MT | Opticians Contractor | VC |
| | | Vascular Surgery | VS |

## EXHIBIT K – Attachment 1 - Form K.1 – Data Certification Form

This form shall be submitted by FAX to (503) 947-5221, following the electronic transmission of the Provider Capacity Report.

I, the undersigned, hereby attest that I have authority to certify the data and information and I, the undersigned, hereby certify based on best knowledge, information and belief that the data and information submitted to DMAP in the Provider Capacity Report is accurate, complete, and truthful.

_____
Print Name/Title

_____ _____
Signature Date

## EXHIBIT L – Member Complaints/Appeals Report

**Contractor Name: _____ Year:_____**

**Report Period: Oct – Dec Jan – Mar Apr – Jun Jul - Sep**

**Instructions:** *Please report the total number of Complaints and Appeals (as defined in OAR 410-141-0000), received by the Contractor in each of the following categories for the report period. This report is to be submitted with documentation of the QI program of complaints (as noted in OAR 410-141-0200) to the Analysis and Evaluation Unit not later than 60 calendar days from the end of each calendar quarter.*

| | **Categorically (Plus** | **Eligible Population)** | **Expansion Population (Standard Population)** |
|---|---|---|---|
| | **Special Needs Phase II** | **Other** | |
| **COMPLAINTS** | | | |
| **Access** | | | |
| **Quality of Clinical Care** | | | |
| **Interpersonal Care/Quality of Service** | | | |
| **Other** | | | |
| **Complaints Totals** | | | |

| | | | |
|---|---|---|---|
| **APPEALS** | | | |
| **Payment for services denied** | | | |
| **Authorization for services denied** | | | |
| **Appeals Totals** | | | |

| | | | |
|---|---|---|---|
| **OVERALL TOTALS** | | | |

**Attach documentation to indicate specifically how the Contractor analyzed Complaints and Appeals for trends, identified persistent or significant Complaints and Appeals, and conducted follow-up actions for this report quarter.**

## Member Complaints / Appeals Report
## Report Definitions

* **In order to obtain consistent and comparative data, DMAP is requesting that the following examples be used as guidelines for capturing both Complaints and Appeals submitted to plans.**
* **ALL member expressions of dissatisfaction must be categorized as a Complaint. NO filters.**
* **There is NO timeline for submission of member Complaints.**

| COMPLAINT RESOLUTIONS TRACKED | APPEALS |
|---|---|
| | |
| | |
| **Access** | **Plan's Payment of Services Denied** |
| Provider's office difficult to contact for appointment or information | Payment for emergency services denied |
| Provider's office has physical barrier | Payment to Non-Participating Provider denied |
| Provider's office too far away, not convenient | |
| Unable to schedule appointment in timely manner | **Plan's Authorization for Services Denied/Limited** |
| Provider's office closed to new patients | Benefit not covered |
| Referral denied / refused by Provider | Urgent / emergent care not provided |
| Unable to be seen in timely manner for urgent / emergent care | Specialty / referral denied |
| Provider(s) not available to give necessary care | Service denied as not medically necessary |
| Provider's office has language or cultural barriers | DME equipment not covered |
| | Cosmetic |
| **Quality of Clinical Care** | Pain Management |
| Adverse outcome, Complications, Misdiagnosis | Pharmacy |
| Testing / assessment insufficient, inadequate or omitted | Physical Therapy / OT denied or reduced |
| Disagreement / member not involved with treatment plan | Other |
| Medical record documentation issues | |
| Medication management issues | |
| Unsanitary environment or equipment | |
| Allegation of abuse | |
| | |
| **Interpersonal Care / Quality of Service** | |
| Provider staff rude or inappropriate comments / behavior | |
| Provider explanation / instruction inadequate, incomplete | |
| Provider / staff unresponsive (unreturned phone calls) | |
| Wait too long in office before receiving care | |
| Concern over confidentiality | |
| Provider office unsafe / uncomfortable | |
| | |
| **Other** | |
| Pharmacy related issues | |
| Benefits, rights and/or financial responsibilities of member | |
| Claims and billing related issues | |
| Availability, delay, quality of materials and supplies (DME) | |
| | |

**NOTE:** Inquiries NOT considered as a Complaint. Eligibility question NOT considered a Complaint.

# EXHIBIT M – Physician Incentive Plan Regulation Guidance

## 1. Background/Authority:

This Contract requires that Contractor's must disclose information about Physician Incentive Plans (PIP) to DMAP. If Contractor utilizes compensation arrangements placing physicians or Physician Groups at Substantial Financial Risk (as defined in this Exhibit) Contractor must also assure provision of adequate PIP Stop-loss Protection and conduct beneficiary surveys.

These Contract requirements implement federal law and regulations to protect DMAP Members against improper clinical decisions made under the influence of strong financial incentives. Therefore, it is the financial arrangement under which the physician is operating that is of interest and potential concern. Consequently, Contractors must report on the "bottom tier" - that is, the arrangement under which the participating physician is operating. The reporting requirement is imposed on Contractors because that is the entity or Physician Group with which DMAP has a contractual relationship and the entity, which is ultimately responsible, under the statute, for making sure that adequate safeguards are in place.

A Physician Incentive Plan (PIP) is defined as "any compensation to pay a physician or Physician Group that may directly or indirectly have the effect of reducing or limiting services furnished to any Contractor enrollee". The compensation arrangements negotiated between Subcontractors of an Managed Care Organization (MCO) (e.g., physician-hospital organizations, IPAs) and a physician or group are of particular importance, given that the compensation arrangements with which a physician is most familiar will have the greatest potential to affect the physician's referral behavior. For this reason, all Subcontracting tiers of the Contractor's arrangements are subject to the regulation and must be disclosed to DMAP.

Note that PIP rules differentiate between Physician Groups and Intermediate Entities. Examples of Intermediate Entities include Individual Practice Associations (IPAs) that contract with one or more Physician Groups, as well as physician-hospital organizations. IPAs that contract only with individual physicians and not with Physician Groups are considered Physician Groups under this rule.

CMS' web site: http://www.cms.hhs.gov/manuals/downloads/mc86c06.pdf can be accessed for the most recent information on disclosure requirements.

## 2. Glossary of Terms:

As used in this Exhibit M, these terms have the following meaning wherever the term is used, unless expressly defined otherwise in this Contract.

**Bonus** means a payment a physician or entity receives beyond any salary, fee-for-service payments, Capitation or returned withhold. Bonuses and other compensation that are not based on referral levels (such as Bonuses based solely on quality of care, patient satisfaction or physician participation on a committee) are not considered in the calculation of Substantial Financial Risk.

**Capitation** means a set dollar payment per patient per unit of time (usually per month) that is paid to cover a specified set of services and administrative costs without regard to the actual number of services provided. The services covered may include a physician's own services, Referral Services or all medical services.

**Panel Size** means the number of patients served by a physician or Physician Group. If the panel is greater than 25,000 patients, then the Physician Group is not considered to be at Substantial Financial Risk because the risk is spread over the large number of patients. PIP Stop-loss Protection and Beneficiary Surveys would not be required.

**Physician Group** means a partnership, association, corporation, Individual Practice Association (IPA), or other group that distributes income from the practice among members. An IPA is a Physician Group only if it is composed of individual physicians and has no subcontracts with other Physician Groups.

**Intermediate Entities** are entities, which contract between Contractor and one of its Subcontractors and a physician or Physician Group, other than Physician Groups themselves. An IPA is considered an Intermediate Entity if it contracts with one or more Physician Groups in addition to contracting with individual physicians.

**Physician Incentive Plan (PIP)** means any compensation arrangement at any contracting level between Contractor and a physician or Physician Group that may directly or indirectly have the effect of reducing or limiting services furnished to DMAP Members. Contractor must report on Physician Incentive Plans between the Contractor itself and individual physicians and groups and also between groups or Intermediate contracting Entities (e.g., certain IPAs, Physician-Hospital Organizations) and individual physicians and groups.

**PIP Stop-loss Protection** refers to insurance required to protect Physicians or Physician Groups to whom Substantial Financial Risk has been transferred.

**Potential Payments** means the maximum anticipated total payments (based on the most recent year's utilization and experience and any current or anticipated factors that may affect payment amounts) that could be received if use or costs of Referral Services were low enough. These payments include amounts paid for services furnished or referred by the physician/group, plus amounts paid for administrative costs. The only payments not included in Potential Payments are Bonuses or other compensation not based on referrals (e.g., bonuses based on patient satisfaction or other quality of care factors).

**Referral Services** means any specialty, Inpatient, Outpatient or laboratory services that are ordered or arranged, but not furnished directly. Situations may arise where services not normally considered Referral Services will need to be considered Referral Services for purposes of determining if a physician/group is at Substantial Financial Risk. For instance, Contractor may require a physician/group to authorize "retroactive" referrals for emergency care received outside the Contractor’s network. In so far as the physician/group can experience an increase in Bonus (if emergency referrals are low) or a reduction in capitation/increase in withhold (if emergency referrals are high), then these Emergency Services are considered Referral Services and need to be included in the calculation of Substantial Financial Risk.

Also, if a Physician Group contracts with an individual physician or another group to provide services, which the initial group cannot provide itself, any services referred to the contracted physician/group should be considered Referral Services.

**Substantial Financial Risk (SFR)** means an incentive arrangement that places the physician or Physician Group at risk for amounts beyond the risk threshold, if the risk is based on the use or costs of Referral Services. The risk threshold is 25%. Calculation of Substantial Financial Risk shall be determined pursuant to Section 4 of this Exhibit.

**Withhold** means a percentage of payments or set dollar amounts that are deducted from a service fee, capitation or salary payment, and that may or may not be returned, depending on specific predetermined factors.

**3. Reporting to DMAP:**

In order to determine compliance with 42 CFR 422.208-422.210, Contractor shall report to DMAP the following information for each medical group and physician providing health services to the DMAP Members:

-Whether any risk is transferred to the Provider
-Whether risk is transferred to the Provider for Referral Services
-What method is used to transfer risk
-What percent of the total Potential Payment to the Provider is at risk for referrals
-What is the number of patients included in the same risk arrangement if the number of patients is 25,000 or fewer, what is the type and amount of PIP Stop-loss Protection insurance
-Whether Contractor's Physician Incentive Plan places physicians or Physician Groups at "Substantial Financial Risk" as determined in Section 4 of this Exhibit M.
-If SFR is established:

**a.** the amount of PIP Stop-loss Protection required; and

**b.** the means for complying with survey requirements

CMS PIP Disclosure Form (OMB No. 0938-0700) or the Physician Incentive Plan Disclosure Form (see Report G.12, Exhibit G), shall be filed with DMAP according to the provisions of Exhibit B, Part IV, Section 1, Subsection e. The CMS PIP Disclosure Form (OMB No. 0938-0700) and instructions and the Physician Incentive Plan Worksheet for Providers can be obtained by accessing CMS' web site:.
http://www.cms.hhs.gov/manuals/downloads/mc86c06.pdf.

**4. Calculation and Determination:**

Contractor shall determine the amount of referral risk by using the following formula:

Amount at risk for Referral Services
Referral Risk = Maximum Potential Payments

The amount at risk for Referral Services is the difference between the maximum potential referral payments and the minimum potential referral payments. Bonuses unrelated to utilization (e.g., quality bonuses such as those related to member satisfaction or open physician panels) should not be counted towards referral payments. Maximum Potential Payments is defined as the maximum anticipated total payments that the physician/group could receive. If there is no specific dollar or percentage amount noted in the incentive arrangement, then the PIP should be considered as potentially putting 100% of the Potential Payments at risk for Referral Services.

The SFR threshold is set at 25% of "Potential Payments" for Covered Services, regardless of the frequency of assessment (i.e. collection) or distribution of payments. SFR is present when the 25% threshold is exceeded. However, if the pool of patients that are included in the risk arrangement exceeds 25,000, the arrangement is not considered to be at SFR because the risk is spread over so many lives. See pooling rules below.

The following incentive arrangements should be considered as SFR:

**a.** Withholds greater than 25 percent of Potential Payments.

**b.** Withholds less than 25 percent of Potential Payments if the physician or Physician Group is potentially liable for amounts exceeding 25 percent of Potential Payments.

**c.** Bonuses that are greater than 33 percent of Potential Payments minus the Bonus.

**d.** Withholds plus Bonuses if the Withholds plus Bonuses equal more than 25 percent of Potential Payments. The threshold Bonus percentage for a particular Withhold percentage may be calculated using the formula: Withhold % = -0.75 (Bonus %)+25%.

**e.** Capitation, arrangements, if the difference between the maximum Potential Payments and the minimum Potential Payments is more than 25 percent of the maximum Potential Payments; or the maximum and minimum Potential Payments are not clearly explained in the physician's or Physician Group's contract.

**f.** Any other incentive arrangements that have the potential to hold a physician or Physician Group liable for more than 25 percent of Potential Payments.

**5.** If Contractor’s Physician Incentive Plan places physicians or Physician Groups at SFR, Contractors shall:

- Establish and maintain PIP Stop-loss Protection, as required in this Section 5, Subsection a, and
- Conduct survey as required in this Section 5, Subsection b

**a.** PIP Stop Loss Protection

Stop-loss Protection must be in place to protect physicians and/or Physician Groups to whom SFR has been transferred. Either aggregate or per patient stop-loss may be acquired. Aggregate insurance is excess loss coverage that accumulates based on total costs of the entire population for which they are at risk and which provides

reimbursement after the expected total cost exceeds a pre-determined level. Individual insurance is where a specific Provider excess loss accumulates based on per member per year Claims.

The rule specifies that if aggregate stop-loss is provided, it must cover 90% of the cost of Referral Services that exceed 25% of Potential Payments. Physicians and groups can be liable for only 10%. If per patient PIP Stop-loss Protection is acquired, it must be determined based on the physician or Physician Group's patient Panel Size (calculated according to Subsection b., of this Exhibit) and cover 90% of the referral costs which exceed the following per patient limits:

| Panel Size | Combined Institutional Professional Professional Deductible | Institutional Deductible | |
|---|---|---|---|
| 1-1000 | $6,000* | $10,000* | $3,000* |
| 1,001 - 5000 | $30,000 | $40,000 | $10,000 |
| 5,001 - 8,000 | $40,000 | $60,000 | $15,000 |
| 8,001 - 10,000 | $75,000 | $100,000 | $20,000 |
| 10,001 - 25,000 | $150,000 | $200,000 | $25,000 |
| > 25,000 | none | none | none |

*The asterisks in this table indicate that, in these situations, PIP Stop-loss insurance would be impractical. Not only would the premiums be prohibitively expensive, but the protections for patients would likely not be adequate for panels of fewer than 500 patients. Contractors and Physician Groups clearly should not be putting physicians at financial risk for Panel Sizes this small. It is our understanding that doing so is not common. For completeness, however, we do show what the limits would be in these circumstances.

The institutional and professional stop-loss limits above represent the actuarial equivalents of the combined institutional and professional deductible. The Physician Group or Contractor may choose to purchase whatever type is best suited to cover the referral risk in the incentive arrangement.

**b.** Pooling Criteria

To determine the Patient Panel Size in the above chart, Contractor may pool according to the specific criteria below. If Contractor meets all five criteria required for the pooling of risk, Contractor is allowed to pool that risk in order to determine the amount of stop-loss required by the regulation:

**(1)** Pooling of patients is otherwise consistent with the relevant contracts governing the compensation arrangements for the physician or group;

**(2)** The physician or group is at risk for Referral Services with respect to each of the categories of patients being pooled;

**(3)** The terms of the compensation arrangements permit the physician or group to spread the risk across the categories of patients being pooled (i.e., payments must be held in a common risk pool);

**(4)** The distribution of payments to physicians from the risk pool is not calculated separately by patient category (either by Contractor or by Medicaid, Medicare, or commercial); and

**(5)** The terms of the risk borne by the physician or group are comparable for all categories of patients being pooled.

**c.** Contractor shall establish a procedure under which their Subcontractors are required to submit stop-loss documentation. Contractors shall collect Stop-loss information from each Subcontractor and shall retain this information for a recommended three (3) years.

**6. Surveys:**

Contractor shall conduct a customer survey of both enrollees and disenrollees if any physician or Physician Groups in the Contractor's network are placed at Substantial Financial Risk for Referral Services, as defined by the Physician Incentive Regulations. If a survey is required it must be conducted in accordance with Section 8, of this Exhibit M. The most current guidance on surveys required by the Physician Incentive Regulation can be found on the CMS web site: http://www.cms.hhs.gov/manuals/downloads/mc86c06.pdf.

**7. Disclosure to DMAP Members:**

At DMAP Member's request, Contractor must provide information indicating whether it or any of its contractors or Subcontractors use a PIP that may affect the use of Referral Services, the type of incentive arrangement(s) used, and whether PIP Stop-loss Protection is provided. If Contractor is required to conduct a survey, it must also provide DMAP Members with a summary of survey results. (See Guidance on Disclosure of Physician Incentive Regulation Information to Beneficiaries at CMS' web site: http://www.cms.hhs.gov/manuals/downloads/mc86c06.pdf.

**8. Monitoring:**

**a.** Contractor shall file the CMS PIP Disclosure Form (OMB No. 0938-0700) or the Physician Incentive Disclosure Form (see Exhibit G, Report G.12), with DMAP according to the provisions of Exhibit B, Part IV, Section 1 Subsection e. The CMS PIP Disclosure Form (OMB No. 0938-0700) can be obtained by accessing the CMS web site: http://www.cms.hhs.gov/manuals/downloads/mc86c06.pdf

**b.** CMS PIP Disclosure Form (OMB No. 0938-0700) and the Physician Incentive Disclosure Form (see Exhibit G, Report G.12), is subject to review by DMAP and subject to correction/clarification.

# EXHIBIT N – Grievance System
## Oregon Health Plan Prepaid Health Plan Grievance System: Contractor Complaint and Appeal Procedures and Access to Administrative Hearings

**The purpose of this Exhibit is to describe Contractor's obligations to create and maintain a Grievance System consistent with the requirements of 42 CFR 438.400 – 438.424.**

### 1. Grievance System Requirements

**a.** Contractor shall have written policies and procedures for a Grievance System that ensures Contractor's compliance with OAR 410-141-0260 to OAR 410-141-0266.

**b.** Contractor shall provide information to all DMAP Members that includes at least:

**(1)** Written material describing the Contractor's Complaint and Appeal procedures, and how to make a Complaint or file an Appeal; and

**(2)** Assurance in all written, oral, and posted material of DMAP Member confidentiality in the Complaint and Appeal processes.

**c.** A DMAP Member or their Representative may file a Complaint and a Contractor level Appeal orally or in writing, and may request a DMAP Administrative Hearing.

**d.** Contractor shall keep all information concerning a DMAP Member's Complaint or Appeal confidential as specified in OAR 410-141-0261 and 410-141-0262.

**e.** Consistent with confidentiality requirements, the Contractor's staff person who is designated to receive Complaints or Appeals, or both, shall begin to obtain documentation of the facts concerning the Complaint or Appeal upon receipt of the Complaint or Appeal.

**f.** Contractor shall afford DMAP Members full use of the Grievance System procedures. If the DMAP Member decides to pursue a remedy through the DMAP Administrative Hearing process, the Contractor shall cooperate by providing to DMAP relevant information that may be required for the Administrative Hearing process.

**g.** Contractor shall treat as an Appeal a DMAP Member's request for a DMAP Administrative Hearing made to DMAP outside of the Contractor's Appeal procedures, or without previous use of the Contractor's Appeal procedures, upon notification by DMAP as provided for in OAR 410-141-0264.

**h.** Under no circumstances shall Contractor discourage a DMAP Member or their Representative from using the DMAP Administrative Hearing process.

**i.** Contractor shall not request Disenrollment of a DMAP Member on the basis of implementation of a DMAP Administrative Hearing decision or a DMAP Member's request for an Administrative Hearing.

**j.** Contractor shall make available a supply of blank Complaint forms (DMAP 3001) in all Contractor administrative offices and in those medical/dental offices where staff have been designated by the Contractor to respond to Complaints. Contractor shall develop an Appeal

form and shall make the forms available in all Contractor administrative offices and in those medical/dental offices where staff have been designated by the Contractor to respond to Appeals.

**k.** The Contractor shall provide information about the Grievance System to all Participating Providers and Subcontractors at the time they enter into a contract with Contractor.

**l.** The Contractor shall maintain logs that are in compliance with OAR 410-141-0266 to document Complaints and Appeals received by the Contractor, and Contractor shall review the information as part of its Quality Improvement strategy.

**m.** A Representative may act for the DMAP Member at any stage in the Grievance System. Contractor shall document the basis on which an individual acts as Representative of the DMAP Member.

## 2. Contractor Complaint Procedures

**a.** A Complaint procedure applies only to those situations in which the DMAP Member or Member's Representative expresses concern or dissatisfaction about any matter other than an "Action." Contractor shall have written procedures to acknowledge the receipt, disposition and documentation of each Complaint from DMAP Members. The Contractor's written procedures for handling Complaints, shall, at a minimum:

**(1)** Address how the Contractor will accept, process and respond to each Complaint from a DMAP Member or Member's Representative, including:

**(a)** Acknowledgment to the DMAP Member or Representative of receipt of each Complaint;

**(b)** Ensuring that DMAP Members who indicate dissatisfaction or concern are informed of their right to file a Complaint and how to do so;

**(c)** Ensuring that each Complaint is transmitted timely to staff who have authority to act upon it;

**(d)** Ensuring that each Complaint is investigated and resolved in accordance with all applicable rules; and

**(e)** Ensuring that the Contractor's staff person(s) who make decisions on the Complaint must be persons who are:

**(i)** Not involved in any previous level of review or decision-making; and

**(ii)** Health Care Professionals who have appropriate clinical expertise in treating the DMAP Member's condition or disease, if the Complaint concerns denial of expedited resolution of an Appeal or if the Complaint involves clinical issues.

**(2)** Describe how the Contractor informs DMAP Members, both orally and in writing, about the Contractor's Complaint procedures;

**(3)** Designate the Contractor's staff member(s) or a designee who shall be responsible for receiving, processing, directing, and responding to Complaints;

**(4)** Include a requirement for Complaints to be documented in the log to be maintained by the Contractor in a manner that is consistent with OAR 410-141-0266.

**b.** The Contractor shall provide DMAP Members with any reasonable assistance in completing forms and taking other procedural steps related to filing and disposition of a Complaint. This includes, but is not limited to, providing interpreter services and toll free phone numbers that have adequate TTY/TTD and interpreter capabilities.

**c.** The Contractor shall assure DMAP Members that Complaints are handled in confidence consistent with ORS 411.320, 42 CFR 431.300 et seq, the HIPAA Privacy Rules, the Oregon counterpart of HIPAA Privacy Rules at ORS 192.518 to 192.524, and other applicable federal and State confidentiality laws and regulations. The Contractor shall safeguard the DMAP Member's right to confidentiality of information about the Complaint as follows:

**(1)** Contractor shall implement and monitor written policies and procedures to ensure that all information concerning a DMAP Member's Complaint is kept confidential, consistent with appropriate use or disclosure as treatment, payment, or health care operations of the Contractor, as those terms are defined in 45 CFR 164.501 and ORS 192.519. The Contractor and any Provider whose services, items or quality of care is alleged to be involved in the Complaint have a right to use this information for purposes of the Contractor resolving the Complaint, for purposes of maintaining the log required in OAR 410-141-0266, and for health oversight purposes, without a signed authorization from the DMAP Member;

**(2)** Except as provided in Paragraph (1) of this subsection, or as otherwise permitted by all other applicable confidentiality laws, Contractor shall ask the DMAP Member to authorize a release of information regarding the Complaint to other individuals as needed for resolution. Before any information related to the Complaint is disclosed under this subsection, the Contractor shall have an authorization for release of information documented in the Complaint file. Copies of the form for authorizing the release of information shall be included in the Contractor's written process.

**d.** The Contractor's procedures shall provide for the disposition of Complaints within the following timeframes:

**(1)** The Contractor shall resolve each Complaint, and provide notice of the disposition, as expeditiously as the DMAP Member's health condition requires, within the timeframes established below;

**(2)** For standard disposition of Complaints and notice to the affected parties, within 5 working days from the date of the Contractor's receipt of the Complaint, the Contractor shall either:

**(a)** Make a decision on the Complaint and notify the DMAP Member; or

**(b)** Notify the DMAP Member in writing that a delay in the Contractor's decision, of up to 30 calendar days from the date the Complaint was received by the Contractor, is necessary to resolve the Complaint. The written notice shall specify the reasons the additional time is necessary.

**e.** The Contractor's decision about the disposition of a Complaint shall be communicated to the DMAP Member orally or in writing within the timeframes specified in Section 2, Subsection d of this Exhibit:

**(1)** An oral decision about a Complaint shall address each aspect of the DMAP Member's Complaint and explain the reason for the Contractor's decision;

**(2)** A written decision must be provided if the Complaint was received in writing. The written decision on the Complaint shall review each element of the DMAP Member's Complaint and address each of those concerns specifically, including the reasons for the Contractor's decision.

**f.** All Complaints made to the Contractor's staff person designated to receive Complaints shall be entered into a log and addressed in the context of Quality Improvement activity (OAR 410-141-0200) as required in OAR 410-141-0266.

**g.** All Complaints that the DMAP Member chooses to resolve through another process, and that the Contractor is notified of, shall be noted in the Complaint log.

**h.** A DMAP Members who is dissatisfied with the disposition of a Complaint may present the Complaint to the DMAP Ombudsman.

## 3. Contractor Appeal Procedures

**a.** The Contractor shall have a system in place for DMAP Members that includes an Appeal process. An Appeal means a request to the Contractor for review of an Action, as those capitalized terms are defined in this Contract. A DMAP Member must complete the Contractor's Appeal process before requesting a DMAP Administrative Hearing. If the DMAP Member initiates an Appeal, it shall be documented in writing by the Contractor and handled as an Appeal.

**b.** An Appeal must be filed with the Contractor no later than 45 calendar days from the date on the Notice of Action required under OAR 410-141-0263. For service authorization decisions not reached within the time frames established in 42 CFR 438.210(d) (which constitutes a denial and is thus an adverse Action), an Appeal must be filed within 45 calendar days of the date that the time frames expire. If Contractor failed to provide a timely Notice of Action, the Appeal may be filed no later than 45 calendar days after Contractor actually mails its Notice of Action.

**c.** The DMAP Member or their Representative, or a Provider acting on behalf of the DMAP Member with the Member's written consent, may file an Appeal with the Contractor either orally or in writing and, unless he or she requests expedited resolution, must follow an oral filing with a written and signed Appeal.

**d.** Contractor shall adopt written policies and procedures for handling Appeals that, at a minimum, meet the following requirements:

**(1)** Give DMAP Members any reasonable assistance in completing forms and taking other procedural steps related to filing and resolution of an Appeal. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capacity;

**(2)** Address how the Contractor will accept, process and respond to such Appeals, including how the Contractor will acknowledge receipt of each Appeal;

**(3)** Ensuring that DMAP Members who receive a Notice of Action described in OAR 410-141-0263 are informed of their right to file an Appeal and how to do so;

**(4)** Ensuring that each Appeal is transmitted timely to staff that have authority to act on it;

**(5)** Ensuring that each Appeal is investigated and resolved in accordance with all applicable rules; and

**(6)** Ensuring that the individuals who make decisions on Appeals:

**(a)** Were not involved in any previous level of review or decision making; and

**(b)** Are Health Care Professionals who have the appropriate clinical expertise in treating the DMAP Member's condition or disease, if an Appeal of a denial is based on lack of Medical Appropriateness or if an Appeal involves clinical issues.

**(7)** Documenting Appeals in the log to be maintained by the Contractor in a manner consistent with the requirements of OAR 410-141-0266.

**e.** The Contractor shall assure DMAP Members that Appeals are handled in confidence consistent with ORS 411.320, 42 CFR 431.300 et seq, the HIPAA Privacy Rules, the Oregon counterpart of HIPAA Privacy Rules at ORS 192.518 to 192.524, and other applicable federal and State confidentiality laws and regulations. The Contractor shall safeguard the DMAP Member's right to confidentiality of information about the Appeal as follows:

**(1)** Contractor shall implement and monitor written policies and procedures to ensure that all information concerning a DMAP Member's Appeal is kept confidential consistent with appropriate use or disclosure as treatment, payment, or health care operations of the Contractor, as those terms are defined in 45 CFR 164.501 and ORS 192.519. The Contractor and any Provider whose authorization, treatment, services, items, quality of care, or request for payment is alleged to be involved in the Appeal have a right to use this information for purposes of resolving the Appeal, for purposes of maintaining the log required in OAR 410-141-0266, and for health oversight purposes by DMAP, without a signed authorization from the DMAP

Member. The information may also be disclosed to DMAP if the DMAP Member requests an Administrative Hearing regarding the Appeal without a signed authorization from the DMAP Member, pursuant to OAR 410-120-1360 (4);

**(2)** Except as provided in Paragraph (1) of this subsection, or as otherwise permitted by all other applicable confidentiality laws, Contractor shall ask the DMAP Member to authorize a release of information regarding the Appeal to other individuals. Before any information related to the Appeal is disclosed under this subsection, the Contractor shall have an authorization for release of information documented in the Appeal file.

**f.** The process for Appeals must:

**(1)** Provide that oral inquiries seeking to Appeal an Action are treated as Appeals (to establish the earliest possible filing date for the Appeal) and must be confirmed in writing, unless the person making the Appeal requests expedited resolution;

**(2)** Provide the DMAP Member a reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing. (The Contractor shall inform the DMAP Member or their Representative of the limited time available in the case of an expedited resolution);

**(3)** Provide the DMAP Member and their Representative an opportunity, before and during the Appeals process, to examine the DMAP Member's file, including medical records and any other documents or records to be considered during the Appeals process; and

**(4)** Include as parties to the Appeal the DMAP Member and their Representative, or the legal Representative of a deceased DMAP Member's estate;

**g.** The Contractor shall resolve each Appeal and provide the Notice of the Appeal Resolution described in Subsections h and i of this section, as expeditiously as the DMAP Member's health condition requires and within the time frames in this section:

**(1)** For the standard resolution of Appeals, the Contractor shall resolve the Appeal and provide a Notice of Appeal Resolution to the DMAP Member or their Representative no later than 45 days from the day the Contractor receives the Appeal. This timeframe may be extended pursuant to Paragraph (3) of this subsection;

**(2)** When the Contractor has granted a request for expedited resolution of an Appeal, the Contractor shall resolve the Appeal and provide a Notice of Appeal Resolution to the DMAP Member or their Representative no later than 3 working days after the Contractor receives the Appeal. This timeframe may be extended pursuant to Paragraph (3) of this subsection;

**(3)** The Contractor may extend the timeframes from Paragraphs (1) or (2) of this subsection by up to 14 calendar days if:

**(a)** The DMAP Member requests the extension; or

**(b)** The Contractor shows (to the satisfaction of DMAP, upon its request) that there is need for additional information and how the delay is in the DMAP Member's interest.

**(4)** If the Contractor extends the timeframes, it shall, for any extension not requested by the DMAP Member, give the DMAP Member a written notice of the reason for the delay.

**h.** For all Appeals, the Contractor shall provide written Notice of Appeal Resolution to the DMAP Member or their Representative. For notice on an expedited resolution, the Contractor shall also make reasonable efforts to provide oral notice.

**i.** The written Notice of Appeal Resolution must include the following:

**(1)** The results of the resolution process and the date it was completed; and

**(2)** For Appeals not resolved wholly in favor of the DMAP Member, the notice must also include the following information:

**(a)** Reasons for the resolution and a reference to the particular sections of the statutes and administrative rules involved for each reason identified in the Notice of Appeal Resolution relied upon to deny the Appeal;

**(b)** The right to request a DMAP Administrative Hearing, and how to do so, which includes attaching the "Notice of Hearing Rights (DMAP 3030) and the Hearing Request Form (DHS 0443). The DMAP 3030 and the DHS 0443 are located on DHS website at the following link: http://dhsforms.hr.state.or.us/Forms/Served/OE3030.pdf, and http://dhsforms.hr.state.or.us/Forms/Served/DV0443.pdf

**(c)** The right to request to receive benefits while the hearing is pending, and how to make the request; and

**(d)** That the DMAP Member may be held liable for the cost of those benefits if the hearing decision upholds the Contractor's Action.

**j.** A DMAP Member may request a DMAP Administrative Hearing not later than 45 days from the date on the Contractor's Notice of Appeal Resolution, consistent with Subsection g, Paragraph (1) of this section. The parties to the DMAP Administrative Hearing include the Contractor as well as the DMAP Member and their Representative, or the Representative of the deceased DMAP Member's estate.

**k.** Contractor shall establish and maintain an expedited review process for Appeals, consistent with OAR 410-141-0265.

**l.** Contractor shall maintain records of Appeals, enter Appeals and their resolution into a log, and address the Appeals in the context of Quality Improvement activity (OAR 410-141-0200) as required in OAR 410-141-0266.

**m.** Continuation of benefits pending Appeal:

**(1)** As used in this section, "timely" filing means filing on or before the later of the following:

**(a)** Within 10 calendar days after the Contractor mails the Notice of Action; or

**(b)** The intended effective date of the Contractor's proposed Action.

**(2)** The Contractor shall continue the DMAP Member's benefits if:

**(a)** The DMAP Member or their Representative files the Appeal timely;

**(b)** The Appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

**(c)** The services were ordered by an authorized Provider;

**(d)** The original period covered by the original authorization has not expired; and

**(e)** The DMAP Member requests extension of benefits.

**(3)** Continuation of benefits pending Administrative Hearing – If, at the DMAP Member's request, the Contractor continues or reinstates the DMAP Member's benefits while the Appeal is pending and the Notice of Appeal Resolution is adverse to the DMAP Member, the benefits must be continued pending Administrative Hearing pursuant to OAR 410-141-0264.

**n.** If the final resolution of the Appeal is adverse to the DMAP Member, that is, upholds the Contractor's Action, the Contractor may recover from the DMAP Member the cost of the services furnished to the DMAP Member while the Appeal was pending, to the extent that they were furnished solely because of the requirements of Subsection m, Paragraph (2) of this section and in accordance with the policy set forth in 42 CFR 431.230(b).

**o.** The Contractor shall promptly correct the Action taken up to the limit of the original request or authorization, retroactive to the date the Action was taken, if the Contractor decides in the DMAP Member's favor, even if the DMAP Member has lost eligibility or the benefit package has changed after the date the Action was taken, including the following:

**(1)** If the Contractor reverses a decision to deny, limit, or delay services that were not furnished while the Appeal was pending, the Contractor shall authorize or provide, and shall pay for, the disputed services promptly, and as expeditiously as the DMAP Member's health condition requires.

**(2)** If the Contractor reverses a decision to deny authorization of services, and the DMAP Member received the disputed services while the Appeal was pending, the Contractor or DMAP will pay for the services in accordance with DMAP policy and rules.

**4. Notice of Action**

**a.** When Contractor (or authorized Subcontractor or Participating Provider acting on behalf of the Contractor) takes or intends to take any Action (including but not limited to denials or limiting prior authorizations of a requested Covered Service(s) in an amount, duration, or scope that is less than requested, or reductions, suspension, discontinuation or termination of a previously authorized service), the Contractor (or authorized Subcontractor or Participating Provider acting on behalf of the Contractor) shall mail a written Notice of Action in accordance with Section 4, Subsection b., of this section to the DMAP Member within the timeframes specified in Subsection c., of this section.

**b.** The written Notice of Action must be a DMAP approved format and it must be used for all denials of a requested Covered Service(s), reductions, discontinuations or terminations of previously authorized Covered Services, denials of Claims payment, or other Action. The Notice of Action must meet the language and format requirements in this Contract, entitled "Informational Materials and Education of DMAP Members and Potential DMAP Members," and must inform the DMAP Member of the following:

**(1)** Relevant information including, but not limited to, the following:

**(a)** Date of Notice of Action;

**(b)** Contractor name;

**(c)** PCP or PCD name;

**(d)** DMAP Member's name and ID number;

**(e)** Date of service or item requested or provided;

**(f)** Who requested or provided the item or service; and

**(g)** Effective date of the Action.

**(2)** The Action the Contractor or its Subcontractor or Participating Provider has taken or intends to take;

**(3)** Reasons for the Action, including but not limited to the following reasons:

**(a)** Treatment is not a Covered Service;

**(b)** The item requires pre-authorization and it was not pre-authorized;

**(c)** The service is not Dentally or Medically Appropriate;

**(d)** The service or item is received in an emergency care setting and does not qualify as an Emergency Service;

**(e)** The person was not a DMAP Member at the time of the service or is not a DMAP Member at the time of a requested service; or

**(f)** The Provider is not on the Contractor's panel and prior approval was not obtained (if such prior authorization would be required under the OHP Rules).

**(4)** A reference to the particular sections of the statutes and administrative rules involved for each reason identified in the Notice of Action pursuant to Subsection (2) of this section;

**(5)** The DMAP Member's right to file an Appeal with the Contractor and how to exercise that right as required in OAR 410-141-0262;

**(6)** The circumstances under which expedited Appeal resolution is available and how to request it;

**(7)** The DMAP Member's right to have benefits continue pending resolution of the Appeal, how to request that benefit(s) be continued, and the circumstances under which the DMAP Member may be required to pay the costs of these services; and

**(8)** The telephone number to contact the Contractor for additional information.

**c.** The Contractor or Subcontractor or Participating Provider(s) acting on behalf of the Contractor shall mail the Notice of Action within the following time frames:

**(1)** For termination, suspension, or reduction of previously authorized OHP Covered Services, the following time frames apply:

**(a)** The notice must be mailed at least 10 calendar days before the date of Action, except as permitted under Sections 2 or 3 of this Exhibit;

**(b)** The Contractor (or authorized Subcontractor or Participating Provider acting on behalf of the Contractor) may mail a notice not later than the date of Action if:

**(i)** The Contractor, Subcontractor or Participating Provider receives a clear written statement signed by the DMAP Member that he or she no longer wishes services or gives information that requires termination or reduction of services and indicates that he or she understands that this must be the result of supplying the information;

**(ii)** The DMAP Member has been admitted to an institution where he or she is ineligible for Covered Services from the Contractor;

**(iii)** The DMAP Member's whereabouts are unknown and the post office returns Contractor, Subcontractor or Participating Provider's mail directed to him or her indicating no forwarding address;

**(iv)** The Contractor establishes the fact that another state, territory, or commonwealth has accepted the DMAP Member for Medicaid services;

**(v)** A change in the level of medical or dental care is prescribed by the DMAP Member's PCP or PCD;

**(vi)** The date of Action will occur in less than 10 calendar days, in accordance with 42 CFR 483.12(a)(5), related to discharges or transfers and long-term care facilities;

**(vii)** There is factual information confirming the death of the DMAP Member;

**(viii)** There is an adverse determination made with regard to the preadmission screening requirements for nursing facility admissions; or

**(ix)** The safety or health of individuals in the facility would be endangered, the DMAP Member's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the DMAP Member's urgent medical needs, or a DMAP Member has not resided in the nursing facility for 30 days (applies only to adverse actions for nursing facility transfers).

**(c)** The Contractor may shorten the period of advance notice to 5 calendar days before the date of the Action if the Contractor has facts indicating that an Action should be taken because of probable fraud by the DMAP Member. Whenever possible, these facts should be verified through secondary sources.

**(2)** For denial of payment, at the time of any Action affecting the Claim;

**(3)** For standard prior authorizations that deny a requested service or that authorize a service in an amount, duration, or scope that is less than requested, the Contractor shall provide Notice of Action as expeditiously as the DMAP Member's health condition requires and within 14 calendar days following receipt of the request for service, except that:

**(a)** The Contractor may have a possible extension of up to 14 additional calendar days if the DMAP Member or the Provider requests the extension; or if the Contractor justifies (to DMAP upon request) a need for additional information and how the extension is in the DMAP Member's interest;

**(b)** If the Contractor extends the timeframe, in accordance with Item (a) above, it shall give the DMAP Member written notice of the reason for the decision to extend the timeframe and inform the DMAP Member of the right to file a Complaint if he or she disagrees with that decision. The Contractor shall issue and carry out its prior authorization determination as expeditiously as the DMAP Member's health condition requires and no later than the date the extension expires.

**(4)** For prior authorization decisions not reached within the timeframes specified in Paragraph (3) of this subsection, (which constitutes a denial and is thus an adverse Action), on the date that the timeframes expire;

**(5)** For expedited prior authorizations, within the timeframes specified in OAR 410-141-0265.

## 5. Contractor Responsibilities in Relation to DMAP Administrative Hearings

**a.** An individual who is or was a DMAP Member at the time of the Notice of Action is entitled to an Administrative Hearing by DMAP regarding a Notice of Appeal Resolution by Contractor that did not resolve the Appeal wholly in favor of the DMAP Member. The DMAP Member must go through the Appeal process with Contractor before requesting an Administrative Hearing. The decision in the Notice of Appeal Resolution is the document that will trigger the right to request an Administrative Hearing.

**b.** If, at the DMAP Member's request, the Contractor continued or reinstated services while the Appeal was pending, the benefits must be continued pending the Administrative Hearing until one of the following occurs:

**(1)** The DMAP Member withdraws the request for an Administrative Hearing;

**(2)** Ten calendar days pass after the Contractor mails the Notice of Appeal Resolution, providing the resolution of the Appeal against the DMAP Member, unless the DMAP Member within the 10-day timeframe, has requested a DMAP Administrative Hearing with continuation of benefits until the DMAP Administrative Hearing decision is reached;

**(3)** A final order is issued in a DMAP Administrative Hearing adverse to the DMAP Member; or

**(4)** The time period or service limits of a previously authorized service have been met.

**c.** Contractor shall immediately transmit to DMAP any Administrative Hearing request submitted on behalf of a DMAP Member, including a copy of the DMAP Member's Notice of Appeal Resolution.

**d.** If the DMAP Member files a request for an Administrative Hearing with DMAP, DMAP will send a copy of the hearing request to the Contractor.

**e.** Contractor shall review an Administrative Hearing Request, which has not been previously received or reviewed as an Appeal, using the Contractor's Appeal process as follows:

**(1)** The Appeal shall be reviewed immediately and shall be resolved, if possible, within 45 calendar days, pursuant to OAR 410-141-0262;

**(2)** The Contractor's Notice of Appeal Resolution shall be in writing and shall be provided to the DMAP Member.

**f.** When an Administrative Hearing is requested by a DMAP Member who has exhausted the Contractor's Appeal process, the Contractor shall cooperate with providing relevant information required for the Administrative Hearing process to DMAP, as well as the results of the review by the Contractor of the Appeal and the Administrative Hearing request, and any attempts at resolution by the Contractor.

**g.** If the final resolution of the Administrative Hearing is adverse to the DMAP Member, that is, if the final order upholds the Contractor's Action, the Contractor may recover the cost of the services furnished to the DMAP Member while the Administrative Hearing is pending, to the extent they were furnished solely because of the requirements of this section, and in accordance with the policy set forth in 42 CFR 438.420.

**h.** The Contractor shall promptly correct the Action taken up to the limit of the original request or authorization, retroactive to the date the Action was taken, if the Administrative Hearing decision is favorable to the DMAP Member, or DMAP or the Contractor decides in the DMAP Member's favor before the Administrative Hearing even if the DMAP Member has lost eligibility or the benefit package has changed after the date the Action was taken, including the following:

**(1)** If the Contractor, or a DMAP Administrative Hearing decision reverses a decision to deny, limit, or delay services that were not furnished while the Administrative Hearing was pending, the Contractor shall authorize or provide, and shall pay for, the disputed services promptly, and as expeditiously as the DMAP Member's health condition requires;

**(2)** If the Contractor, or the DMAP Administrative Hearing decision reverses a decision to deny authorization of services, and the DMAP Member received the disputed services while the Administrative Hearing was pending, the Contractor shall pay for the services in accordance with DMAP policy and regulations in effect when the DMAP Member made the request for services.

## 6. Request for Expedited Appeal or Expedited Administrative Hearing

**a.** Contractor shall establish and maintain an expedited review process for Appeals, when the Contractor determines (upon request from the DMAP Member) or the Provider indicates (in making the request on a DMAP Member's behalf or supporting the DMAP Member's request) that taking the time for a standard resolution could seriously jeopardize the DMAP Member's life, health, or ability to attain, maintain or regain maximum function.

**b.** The Contractor shall ensure that punitive action is not taken against a Provider who requests an expedited resolution or supports a DMAP Member's Appeal.

**(1)** If the Contractor provides an expedited Appeal, but denies the services or items requested in the expedited Appeal, the Contractor shall inform the DMAP Member of the right to request an expedited Administrative Hearing and shall provide the DMAP Member with a copy of both the DHS Form 0443 and Notice of Hearing Rights (DMAP 3030) with the Notice of Appeal Resolution. The DMAP 3030 and the DHS 0443 are located on DHS website at the following link: http://dhsforms.hr.state.or.us/Forms/Served/OE3030.pdf, and http://dhsforms.hr.state.or.us/Forms/Served/DV0443.pdf

**c.** If the Contractor denies a request for expedited resolution on Appeal, it shall:

**(1)** Transfer the Appeal to the time frame for standard resolution in accordance with OAR 410-141-0262; and

**(2)** Make reasonable efforts to give the DMAP Member prompt oral notice of the denial, and follow-up within two calendar days with a written notice. The written notice must state the right of a DMAP Member, who believes that taking the time for a standard resolution of a request for an Administrative Hearing, could seriously jeopardize the DMAP Member's life or health or ability to attain, maintain or regain maximum function, to request an expedited Administrative Hearing.

**d.** The Contractor shall submit relevant documentation to DMAP's Medical Director within, as nearly as possible, two working days following the DMAP Member's expedited Administrative Hearing request for a decision as to the necessity of an expedited Administrative Hearing.

**7. The Contractor's Responsibility for Documentation and Quality Improvement Review of the Grievance System**

**a.** The Contractor's documentation shall include, at minimum, a log of all oral and written Complaints and Appeals received by the Contractor. The log shall identify the DMAP Member and the following additional information:

**(1)** For Complaints, the date of the Complaint, the nature of the Complaint, the disposition and date of disposition of the Complaint;

**(2)** For Appeals, the date of the Notice of Action, the date of the Appeal, the nature of the Appeal, whether continuing benefits were requested and provided, the resolution and date of resolution of the Appeal. If an Administrative Hearing was requested, whether continuing benefits were requested and provided, and the effect of the final order of the Administrative Hearing.

**b.** The Contractor shall also maintain a record for each of the Complaints and Appeals included in the log. The record shall include records of the review or investigation and resolution, including all written decisions and copies of correspondence with the DMAP Member. The Contractor shall retain documentation of Complaints and Appeals for the term of the OHP Demonstration Project plus two years to permit evaluation. This requirement survives the termination or expiration of this Contract.

**c.** The Contractor shall have written procedures for the review and analysis of the Grievance System, including all Complaints and Appeals received by the Contractor. The analysis of the Grievance System shall be forwarded to the Quality Improvement committee as necessary to comply with the Quality Improvement standards:

**(1)** Contractor shall monitor the completeness and accuracy of the written log, on a monthly basis; and

**(2)** Contractor's monitoring of Complaints and Appeals shall include, at minimum, review of completeness, accuracy, timeliness of documentation, and compliance with written procedures for receipt, disposition, and documentation of Complaints and Appeals, and compliance with OHP rules.

# SCHEDULE 1 – Asthma Care Measure

**Please use the QPI Asthma Performance Measure Specifications for directions on how to fill out this spreadsheet. Fill in the plan name, the updated date, and cells that are colored gray. This workbook contains the following spreadsheets:**

Indicator Spreadsheet - Raw Data  Indicator Calculation Spreadsheet

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | **Name of person who filled out template:** | | | | | | | | | | |
| | **Plan name:** | **STANDARD BENEFIT** | | | | | **PLUS BENEFIT** | | | | |
| | **Updated:** | **Age on December 31, 2007** | | | | | **Age on December 31, 2007** | | | | |
| | **Indicator Spreadsheet - Raw Data** | **Age 4 to 8** | **Age 9 to 16** | **Age 17 to 55** | **Total** | | **Age 4 to 8** | **Age 9 to 16** | **Age 17 to 55** | **Total** | |
| **1** | **# of Members who had 6 months enrollment between 1/1/2007 and 12/31/2007 (on CD from DMAP)** | | | | 0 | | | | | 0 | Task #1 |
| **2** | **# of Members who met asthma criteria** | | | | 0 | | | | | 0 | |
| **2a** | **Sum total of the months enrolled for those members who met asthma criteria** | | | | 0.0 | | | | | 0.0 | Task #6 |
| **3** | **# of Members who met persistent asthma criteria** | | | | 0 | | | | | 0 | |
| **3a** | **Sum total of the months enrolled for those members who met persistent asthma criteria** | | | | 0.0 | | | | | 0.0 | Task #8 |
| **4** | **# Members who met the asthma criteria and had >=1 ED visit with primary asthma dx** | | | | 0 | | | | | 0 | Task #9 |
| **4a** | **Sum total of the months enrolled for the Members who met #4 criteria** | | | | 0.0 | | | | | 0.0 | |
| **5** | **# of ED visits with a primary asthma dx** | | | | 0 | | | | | 0 | Task #10 |
| **6** | **# of ED visits with a primary asthma diagnosis that had an Outpatient visit with a respiratory diagnosis >=1 to <=30 days after that ED visit** | | | | 0 | | | | | 0 | Task #11 |
| **7** | **# of Members who met the persistent asthma criteria and who had >= 1 inhaled corticosteroid (ICS) dispensings** | | | | 0 | | | | | 0 | Task #13 |
| **7a** | **Sum total of the months enrolled for the Members who met #7 criteria** | | | | 0.0 | | | | | 0.0 | |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **8** | **# of Members who met the persistent asthma criteria and who had > 0.5 inhaled short-acting bronchodilator (SAB) dispensings (in the form of metered dose inhalers (MDIs) or nebulizers) per month enrolled [Standard]** | | | | 0 | | | | | 0 | Task #15 |
| **8a** | **Sum total of the months enrolled for the Members who met #8 criteria** | | | | 0.0 | | | | | 0.0 | |
| **9** | **# of Members who met the persistent asthma criteria and who had > 0.5 SAB MDI canisters or SAB nebulizer dispensings converted to canisters per month enrolled [Enhanced]** | | | | 0 | | | | | 0 | Task #17 |
| **9a** | **Sum total of the months enrolled for the Members who met #9 criteria** | | | | 0.0 | | | | | 0.0 | |
| **10** | **# of Members who met the persistent asthma criteria and who had 2 or more inhaled SAB canisters or nebulizer dispensings in a year.** | | | | 0 | | | | | 0 | Task #19 |
| **10a** | **Sum total of the months enrolled for Members who met #10 criteria.** | | | | 0.0 | | | | | 0.0 | |
| **11** | **# of Members who met the persistent asthma criteria, had 2 or more inhaled SAB canisters, and had a ratio of ICS canisters to the sum of ICS and inhaled SAB canisters (in MDI or nebulizer form) that is >=0.33.** | | | | 0 | | | | | 0 | Task #20 |
| **11a** | **Sum total of the months enrolled for Members who met #11 criteria.** | | | | 0.0 | | | | | 0.0 | |
| **12** | **# of Members who met the persistent asthma criteria, had 2 or more inhaled SAB canisters, and had a ratio of ICS canisters to the sum of ICS and inhaled SAB canisters (in MDI or nebulizer form) that is >=0.50.** | | | | 0 | | | | | 0 | Task #21 |
| **12a** | **Sum total of the months enrolled for Members who met #12 criteria.** | | | | 0.0 | | | | | 0.0 | |

| | Indicator Calculation Spreadsheet | Age on December 31, 2007 Age 4 to 8 | Age 9 to 16 | Age 17 to 55 | Total | | Age on December 31, 2007 Age 4 to 8 | Age 9 to 16 | Age 17 to 55 | Total | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1a | % of Members who met the asthma criteria and who had >=1 ED visit with primary asthma dx, in member months | | | | | | | | | | Indicator 1 - Part a |
| 1b | % of ED visits with a primary asthma dx that had Outpatient visit with a respiratory dx >=1 to <=30 days after the ED visit | | | | | | | | | | Indicator 1 - Part b |
| 2a | % of Members who met the persistent asthma criteria and who had >=1 inhaled corticosteroid (ICS) dispensings in the past year, in member months | | | | | | | | | | Indicator 2 - Part a |
| 2b | % of Members who met the persistent asthma criteria and who had >0.5 inhaled short-acting bronchodilator (SAB) MDI or nebulizer dispensings per month enrolled in the past year, in member months | | | | | | | | | | Indicator 2 - Part b |
| 2c | % of Members who met the persistent asthma criteria and who had >0.5 inhaled SAB canisters or nebulizer dispensings per month enrolled of the past year, in member months | | | | | | | | | | Indicator 2 - Part c |
| 2d | % of Members who met the persistent asthma criteria and had 2 or more inhaled SAB canisters, who had a medication ratio >=0.33, in member months (see the tech specs for a description of the ratio) | | | | | | | | | | Indicator 2 - Part d |
| 2d' | % of Members who met the persistent asthma criteria, had 2 or more inhaled SAB canisters, and who had a medication ratio >=0.50, in member months (see the tech specs for a description of the ratio) | | | | | | | | | | Indicator 2 - Part d' |

## SCHEDULE 2 – Performance Improvement Projects (PIP)

The projects included in this Schedule 2 are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time and are expected to have a favorable effect on health outcomes.

If Contractor does not have performance improvement projects meeting the standards identified in Exhibit B, Part II, Section 3, Subsection d.(1), Contractor must conduct a minimum of two performance improvement projects to meet this requirement. For this Contract Year the performance improvement projects are asthma and the mental health/ physical health Collaborative PIP.

Contractor shall submit to DMAP the asthma project baseline (due March 15, 2008), worksheet and remeasurement (due August 1, 2008) as instructed in this Schedule 2. The State will complete Activity 1 for the asthma project. The project will be documented on a PIP worksheet found in the Conducting Performance Improvement Projects and reproduced in this Schedule 2.

Contractor shall submit to DMAP the Collaborative project baseline minimum requirement of Activity 1, 2 and 3 (due March 15, 2008), worksheet, and re-measurement (due August 1, 2009) as instructed in this Schedule 2. The State will complete Activity 1 for the mental health/ physical health Collaborative PIP. The project will be documented on a PIP worksheet found in the Conducting Performance Improvement Projects and reproduced in this Schedule 2.

### Program Requirements

The purpose is to promote and implement performance improvement initiatives and services for Contractor's DMAP Members through a health systems improvement process. Contractor must demonstrate on-going activities and improvements over time. Contractor must designate at least one staff person to participate in the Quality and Performance Improvement (QPI) Workgroup meetings. This staff person is generally responsible for the implementation of the performance improvement projects developed by the Quality and Performance Improvement Workgroup within Contractor's plan and will report how Contractor has met the minimum necessary requirements listed below:

**1.** Develop and implement performance improvement projects, as required in this Contract, Exhibit B, Part II, Section 3, Subsection d.(1), or for asthma and the Collaborative PIP designed to demonstrate significant improvement, sustained over time;

**2.** Provide presentations on the performance improvement projects to the Quality and Performance Improvement Workgroup and, if requested, the OHP Medical Director's Group;

**3.** Provide annual written performance improvement project baseline, worksheets and remeasurement on each performance improvement topic to DMAP (see attached project worksheet forms) and;

**4.** Projects must contain elements in the PIP Annual plan.

**5.** Evidence of sustainability of previous PIP projects must be documented and submitted to DMAP by March 15 of each Contract Year, for the previous calendar year, as an inclusion of the annual QI report. This includes updated tobacco cessation data as outlined by DMAP in Parts B and C of the Tobacco Cessation Milestone Report DMAP and documentation of sustainability of the activities and interventions to promote early childhood cavities prevention (ECCP).

Other prevention activities as identified and agreed upon by Contractor and DMAP, or as mandated by the Centers for Medicare and Medicaid Services.

## SCHEDULE 2 – Attachment 1 - Form 2.1 – Asthma project Report Instructions

## PIP Annual Plan

## FCHP Performance Improvement Project (PIP)

Asthma Care – Measure Description

**Study Questions**

Does a plan intervention with members who met the asthma criteria [1] and/or Provider system significantly increase the rate of 30-day follow-up Outpatient visit after an ED visit for asthma?
**Favorable rate – High**

**And/Or**

Does a plan intervention with Providers show a significant increase in the percentage of members who met the persistent asthma criteria [2] (and had two or more short-acting inhaled bronchodilator dispensings) and had a medication ratio greater than or equal to 0.33 and 0.5?
**Favorable rate - High**

**Timelines and Tasks**

**2008**
Each FCHP will submit to DMAP by March 15, 2008 their baseline measurement – calendar year 2007.
The re-measurement year is calendar year 2008.

FCHPs' targeted interventions provided in 2008 will be re-measured (will be calculated by each FCHP in 2009).

**2009**
The re-measurement is of calendar year 2008 – each FCHP will calculate their re-measurement and submit to DMAP by August 1, 2009.

**Study Question A**

For continuously enrolled members with asthma, the percentage of ED visits with a primary discharge diagnosis of asthma that have a follow-up Outpatient visit within 30 days.

**Denominator**
ED visits (1/1/05 through12/31/05 for the baseline year and 1/1/07 through12/31/07 for the re-measurement year) with primary diagnosis of asthma by continuously enrolled members with asthma [3].

[1] Asthma criteria defined in the QPIWG Asthma 2006 Performance Measures Specifications
[2] Persistent asthma criteria defined in the QPIWG Asthma 2006 Performance Measures Specifications

[3] See QPIWG Asthma 2006 Performance Measure Specifications for definition of primary diagnosis of asthma and continuously enrolled member with asthma.

**Numerator**
Of the ED visits in the denominator, how many had an Outpatient visit with diagnosis codes 460 – 519 [4] (in any diagnosis position) within 30 days of the ED visit. (Service dates 1/2/05 through 1/30/06 for baseline follow-up visits and look for service dates1/2/07 through 1/30/08 for re-measurement follow-up visits)

**Study Question B**

For continuously enrolled members with persistent asthma with two or more short-acting inhaled bronchodilator canisters and/or nebulizer dispensings, the percentage that have a medication ratio greater than or equal to 0.33 and0.5.

**Denominator**
Total number of continuously enrolled members with persistent asthma with two or more short-acting inhaled bronchodilator canisters and/or nebulizer dispensings.

**Numerator**
Number of continuously enrolled members with persistent asthma with two or more short-acting inhaled bronchodilator canisters and/or nebulizer dispensings and had a medication ratio greater than or equal to 0.33 and 0.5.

Ratio = (canisters of inhaled corticosteroid) divided by (canisters of inhaled corticosteroid + canisters of short-acting inhaled bronchodilator + inhaled short-acting inhaled bronchodilator nebulizer dispensings)

[4] ICD-9 codes 460 – 519 are all categories of diseases of the respiratory system in the ICD-9 nomenclature.

## SCHEDULE 2 – Attachment 2 - Form 2.2 – The Collaborative PIP Instructions

## CONDUCTING PERFORMANCE IMPROVEMENT PROJECT WORKSHEET

Use this or a similar worksheet as a guide while designing and conducting performance improvement projects. Document the completion of each step. Refer to the protocol for detailed information on each area.

<table>
<tr><th colspan="3">Demographic Information</th></tr>
<tr><td colspan="3">MCO/PIHP Name or ID:</td></tr>
<tr><td colspan="3">Project Leader Name:</td></tr>
<tr><td colspan="3">Telephone Number:</td></tr>
<tr><td colspan="3">Name of Performance Improvement Project</td></tr>
<tr><td colspan="3">Date of Study Period: / / to / / /</td></tr>
<tr><td colspan="3">Type of Delivery System (check all that are applicable)</td></tr>
<tr><td>____ Staff Model<br>____ Network<br>____ Direct IPA<br>____ IPA Organization</td><td>____ MCO<br>____ PIHP</td><td>_____ Number of Medicaid Enrollees in MCO or PIHP<br>_____ Number of Medicare Enrollees in MCO or PIHP<br>_____ Number of Medicaid Enrollees in Study<br>_____ Total Number of MCO or PIHP Enrollees in Study</td></tr>
<tr><td colspan="3">Number of MCO/PIHP primary care physicians _____<br>Number of MCO/PIHP specialty physicians _____</td></tr>
</table>

| Number of physicians in study _____ | | |
|---|---|---|
| **Component/Standard Number** | **Comments** | **Date Comp.** |
| **Activity 1. SELECT THE STUDY TOPIC(S)** | | |
| 1.1 Study topic is selected through data collection and analysis of comprehensive aspects of enrollee needs, care and services. | | |
| 1.2 The topic(s), over time, address a broad spectrum of key aspects of enrollee care and services. | | |
| 1.3 The topics, over time, include all enrolled populations: i.e., do no exclude certain enrollees such as those with special health care needs | | |
| **Activity 2. DEFINE THE STUDY QUESTION(S)** | | |
| 2.1 The study question(s) is/are clearly stated in writing. | | |
| **Activity 3. SELECT STUDY INDICATOR(S)** | | |
| 3.1. The study has objective, clearly defined, measurable indicators. | | |
| 3.2. The indicators measure changes in health status, functional status, or enrollee satisfaction, or valid proxies of these outcomes. | | |
| **Activity 4. USE A REPRESENTATIVE AND GENERALIZABLE STUDY POPULATION** | | |
| 4.1. The at-risk population is defined. | | |
| 4.2. If the study includes the entire population, the data collection approach captures all enrollees to whom the study question applies. | | |
| **Activity 5. USE SOUND SAMPLING TECHNIQUES** | | |
| 5.1. The sampling technique considers and specifies the true frequency of occurrence, the confidence interval and the margin of error. | | |
| 5.2. A sufficient number of enrollees are sampled. | | |
| 5.3. Valid sampling techniques are used. | | |
| **Activity 6. RELIABLY COLLECT DATA** | | |
| 6.1. The data to be collected are clearly specified. | | |
| 6.2. The sources of data are clearly specified. | | |
| 6.3. The methods of collecting data are clearly defined. | | |
| 6.4. The data collection instruments provide for consistent, accurate data collection. | | |
| 6.5. The study design specifies a data analysis plan. | | |
| 6.6. Qualified staff and personnel are used to collect the data. | | |

| | | |
|---|---|---|
| **Activity 7. IMPLEMENT INTERVENTION AND IMPROVEMENT STRATEGIES** | | |
| 7.1 Reasonable interventions are undertaken to address causes/barriers identified through data analysis and QI processes undertaken. | | |
| **Activity 8. ANALYZE DATA AND INTERPRET STUDY RESULTS** | | |
| 8.1. Analysis of findings are conducted according to the data analysis plan. | | |
| 8.2. Results and findings present numerical data in a way that provides accurate, clear and easily understood information. | | |
| 8.3. The analysis identifies initial and repeated measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity. | | |
| 8.4. The analysis includes an interpretation of the extent to which the PIP was successful and follow-up activities. | | |
| **Activity 9: PLAN FOR "REAL" IMPROVEMENT** | | |
| 9.1. The same methodology as the baseline measurement is used, when measurement is repeated. | | |
| 9.2. An analysis is conducted to determine if there is quantitative improvements in processes or outcomes of care. | | |
| 9.3. An assessment is made to determine if improvement in performance has face validity | | |
| 9.4. An analysis is conducted to determine statistical evidence of observed improvement. | | |
| **Activity 10: ACHIEVE SUSTAINED IMPROVEMENT** | | |
| 10.1. Repeated measurements is conducted to determine sustained improvement. | | |

## SCHEDULE 3 – Pharmacy Expense Reports - Report 3.1 – Pharmacy Expense Proprietary Exemption Request Form

Contractor _____

Report Period: _____ through _____

DMAP requires Contractors to provide information for purposes of evaluating that, but for this Contract, would not be disclosed to individuals or entities outside of the Contractor's organization. Under ORS 192.501(2), DMAP may conditionally withhold from disclosure records that meet all four of the following criteria:

**1.** The information must not be patented;
**2.** The information must be known only to certain individuals within the organization and used for business the organization conducts;
**3.** The information must have actual or potential commercial value; and
**4.** The information must give its users an opportunity to obtain a business advantage over competitors who do not know or use it.

**Indicate whether Contractor considers the following information submitted to DMAP under this Contract to meet all of the above listed criteria:**

_____ Pharmacy Expense (K2)

_____ Notes to Pharmacy Expense (K2)

Signed _____

Print Name _____

Title _____

Date _____

Also reference: OAR 410-141-0020(2)(a) and 410-141-0180(5)(f)

Submit Report Q.1 along with Report Q.2 to:
OHP Actuarial Services Unit manager
500 Summer St. NE, E-26
Salem, OR 97301-1098

## SCHEDULE 3 – Pharmacy Expense Reports - Report 3.2 – Pharmacy Expense Proprietary Exemption Request Form

Contractor _____

Report Period: _____ through _____

Pharmacy Benefit Manager (PBM) _____

Report Q.2 is an annual requirement. The Report Period will include all data from the prior calendar year and the report is due March 31.

Submit Report Q.2 to:
OHP Actuarial Services Unit manager
500 Summer St. NE, E-26
Salem, OR 97301-1098

For the Report Period, provide information for the Contractor's 1) OHP Contract Line of Business and 2) Corporate Line of Business. If separate accounts are not kept for OHP Contract Line of Business, Contractor shall use an allocation methodology approved by DMAP to determine the information required for this Report. Contractor will describe the allocation methodology and assumptions in Notes to Report Q.2.

**1.** Provide a description of contractual arrangements with PBM, including:

**a.** The contractual discount percentage(s) from Average Wholesale Price (AWP) Contractor received from PBM during the Report Period and/or a summary description of the amount and type of any other pricing arrangements between Contractor and PBM not based on a percentage discount from AWP.

**b.** The dispensing fees associated with each category or type of prescription (for example: generic, brand name).

**c.** The administrative fee paid to PBM by Contractor during the Report Period, including a description of the associated administrative fee for each category or type and a description of the amount and type of any other administrative fees paid to PBM by Contractor.

**d.** The total dollar amount of all pharmacy rebates, incentive programs, or other program refunds received by Contractor during the Report Period, by calendar quarter, and indicate if reported on cash or accrual basis.

**2.** Provide a description of the source data for the "amount billed" field submitted electronically with Pharmacy Data, as described in Schedule 4, Section 2 Subsection b. Paragraph (8). The source data will remain consistent for the Report Period.

## SCHEDULE 4 – Pharmacy Data Requirements and Corrective Action

The information in this Schedule 4 applies to Pharmacy Data Transaction procedures for dates of service in effect on and after the date this Contract was signed. The parties to the Contract acknowledge and agree that the Contractor will transmit data to DMAP using the Health Insurance Portability and Accountability Act (HIPAA) Transaction Standards for Health Care Pharmacy Claims or Equivalent Pharmacy Data as specified by the National Council for Prescription Drug Programs (NCPDP) in 45 CFR 162.1001 and 162.1102.

**a.** Contractor shall take all necessary actions required by the Department of Human Services to become a trading partner and to register and conduct data transactions. The parties shall comply with DHS Electronic Data Interchange (EDI) Rules; OAR 410-001-0100 et seq., applicable to the conduct of Pharmacy Transactions with trading partners.

**b.** Upon Contractor's compliance with testing and other requirements in the DHS EDI rules, and when DHS determines that Pharmacy Transactions may be placed into the production environment, Contractor shall comply with the data requirements in this Schedule.

The parties understand and agree that this Schedule 4 may be further amended for purposes of complying with 45 CFR Parts 160 and 162.

### 1. General Provisions

Contractor must submit retail Pharmacy Data for drugs and biologics for each Pharmacy Transaction for Contractor's DMAP Member. This does not include supplies, or other items used in health care services that are commonly submitted on a CMS1500 or the HIPAA 837 professional equivalent format and billed with HCPCS codes.

#### a. Pharmacy Data Definitions

**(1)** **"Adjudicate"** is Contractor's determination that an DMAP Member's encounter for services are either; accepted as Contractor's liability, not accepted as Contractor's liability, partially accepted as Contractor's liability or the need for additional information in order for Contractor to determine Contractor's liability.

**(2)** **"Corrective Action Plan"** is an DMAP initiated request for Contractor to develop and implement a time specific plan that is acceptable to DMAP for the correction of DMAP identified areas of noncompliance, as described in this Schedule 4 and Exhibit B, Part VI, Section 2, Sanctions.

**(3)** **"Encounter Data"** means health care Claims or equivalent encounter information transaction transmitting either of the following:

**(i)** A request to obtain payment, and the necessary accompanying information from a Provider to Contractor, for health care or

**(ii)** If there is no direct Claim, because the reimbursement contract is based on a mechanism other than charges or reimbursement rates for specific services, the transaction of encounter information for the purpose of reporting Contractor's health care.

**(4)** **"Encounter Only Provider"** is a Provider that provides Medicaid services to OHP Clients only as a Subcontractor to Contractor.

**(5)** **"Pharmacy Data"** are the accumulation of multiple Pharmacy Transactions.

**(6)** **"Pharmacy Transaction" or "Transaction"** is a pharmacy service(s) approved and accepted by Contractor for drugs and biologics administered or delivered to DMAP Members through a prescription transaction.

**(7)** **"Report Errors"** are Pharmacy Transactions that process through DMAP's designated system edits, but are to alert Contractor of possible errors, such as DMAP Member name missing.

**(8)** **"Validation Period"** is the Contract Year, as described in Contract, Definitions, or as specified in a duly executed amendment.

**b. Pharmacy Data Submission and Processing**

**(1)** Contractor must submit Pharmacy Data at least once per calendar month. The Data must represent at least 50% of all the Transactions received and Adjudicated by Contractor during that month.

**(2)** Contractor shall submit all approved and accepted Pharmacy Data to DMAP within 180 days of the date of service.

**(3)** DMAP shall notify Contractor monthly of the status of all Pharmacy Data processed the previous month.

**(4)** Contractor shall submit any corrections to Pharmacy Data within 63 days of the date DMAP sends Contractor a notice. Transactions for correction that are not submitted within 63 days are subject to Corrective Action. *See III.A.7. Timeliness Errors in Resubmitted Pharmacy Transactions.*

**(5)** To prevent Corrective Action, Contractor may submit documentation to DMAP citing specific circumstances, which delay Contractor's timely submittal of original Pharmacy Data (within 180 days from the date of service). DMAP will review the documentation and make a determination within 30 days on whether the circumstances cited are Acceptable. These "Acceptable" circumstances may include, but are not limited to:

**(i)** DMAP Member's failure to give the Provider necessary eligibility information,

**(ii)** Third-Party Resource liability coordination,

**(iii)** Delays associated with resolving out-of-area Transactions,

**(iv)** Third-Party submitter coordination,

**(v)** Hardware or software modifications,

**(vi)** Staffing, and

**(vii)** DMAP recognized system issues preventing timely submission of corrections.

**(6)** Contractor shall submit Transactions even if Contractor did not make any payment for a Transaction, including transactions for services to enrolled DMAP Members provided under subcontract, capitation or special arrangement.

**(7)** Contractor is not responsible for submitting a Pharmacy Transaction if no Transaction has been submitted to Contractor.

**c. Data Transmission and Format**

**(1)** Contractor must submit all Pharmacy Data to DMAP electronically.

**(2)** Contractor must submit all Pharmacy Data asset forth in the DHS NCPDP Companion Guide.

**2. Data Set Requirements**

**a.** The Data Elements specified in this section constitute the minimum data elements required for DHS processing. Contractor is required to submit all of the data elements specified in this section. Non-compliance shall be considered a breach of the terms of the Contract.

**b.** Contractor shall submit the following identifying information for all Pharmacy Transactions:

**(1)** Contractor's DMAP Prepaid Health Plan Provider number or the National Plan Identifier, when available,

**(2)** DMAP Member name,

**(3)** DMAP Member number, also known as the DMAP prime number,

**(4)** For the dispensing pharmacy Provider the NPI and Provider Taxonomy Code, as applicable, must be used pursuant to 45 CFR 162.410 and 162.412,

**(5)** National Drug Code (NDC),

**(6)** Quantity,

**(7)** Dispense date,

**(8)** Amount billed (See Exhibit K, K2 Report line item #2),

**(9)** Optional for the prescribing Provider, NPI and Provider Taxonomy Code, as applicable, must be used pursuant to 45 CFR 162.410 and 162.412,

**(10)** Prescription number,

**(11)** Refill number,

**(12)** Days supplied, and

**(13)** Dispense as written (DAW) indicator.

NOTE: DME supplies provided by a pharmacy must be submitted in the HIPAA 837 professional format as specified in Exhibit H, not the NCPDP format as specified in this Schedule 4.

**c.** The use of DMAP default Provider numbers including default NPIs are not acceptable as the Provider number. Only NPI and taxonomy codes for covered entities registered with DMAP are allowed in Encounter Data.

**d.** Contractor shall ensure that all Contractor's subcontracted Providers are enrolled with DMAP as either a Medicaid Provider or an Encounter Only Provider prior to submission of Encounter Data. Encounter Only Providers are enrolled using DMAP 3108 form, available at: http://egov.oregon.gov/DHS/healthplan/forms/omapforms.shtml#3100. A Form 3108 submitted without all required information will not be accepted and will be returned to Contractor.

**e.** If DMAP discovers errors with previously required and submitted Pharmacy Data defined in this Schedule 4, for that Contract Year resulting from a federal or State mandate or request that requires the completeness and accuracy of the Pharmacy Data, Contractor shall be required to correct the errors. If CMS requests data that DMAP is unable to provide that was previously defined in this Schedule 4, for that Contract Year, the cost of gathering that data shall be borne by the Contractor.

**f.** DMAP shall not impose Sanctions on Contractor for Pharmacy Data affected by DMAP system limitations.

## 3. Error Types and Data Elements

### a. Error Types

DMAP may look for the following types of errors when validating Pharmacy Data:

**(1)** **"Accuracy Errors"** are differences between the information in Contractor's DMAP Member medical records and the Pharmacy Data reported by Contractor to DMAP.

**(2)** **"Inadequate Submission Errors"** occur when Contractor fails to submit at least 50% of all Pharmacy Data Contractor receives or Adjudicates in a one-month period to DMAP at least once per calendar month.

**(3)** **"Missing Medical Record Errors"** are Pharmacy Transactions, which the Contractor is unable to provide the complete medical record.

**(4)** **"Omission Errors"** are Pharmacy Transactions that are not submitted to DMAP.

**(5)** **"Resubmission Errors"** are Pharmacy Transactions that have been resubmitted for correction and receive another error(s) after resubmission.

**(6)** **"Timeliness Errors"** are Pharmacy Transactions for which the time period between the date the Pharmacy Data is submitted to DMAP by Contractor and the date of service is greater than 180 days.

**(7)** **"Timeliness Errors in Resubmitted Pharmacy Transactions"** are Pharmacy **Transactions** that Contractor has not resubmitted within 63 days of the date DMAP sends Contractor a notice. Timeliness Errors occur each 63-day period thereafter that the Pharmacy Transaction remains in an Error status without successfully being corrected.

**(8)** **"Timeliness In Corrective Action Errors"** are Pharmacy Transactions for which Contractor has not submitted corrections within 63 days of the date DMAP sends Contractor a notice that Pharmacy Transactions need to be corrected.

**b. Data Elements for Validation Methodology**

**(1)** For **purposes** of Corrective Action, DMAP shall consider the mandatory Data Elements listed in Section 2, Data Set Requirements, of this Exhibit.

**(2)** DMAP may conduct validations, quality checks and analyses of Pharmacy Data previously received from Contractor at DMAP's sole discretion and without notice to Contractor.

**4. Timeliness**

**a.** DMAP will not take Corrective Action for Timeliness Errors, if the error occurred as the result of DMAP's Pharmacy Data system problem and are beyond the control of the Contractor. If the Timeliness Errors are the result of Contractor's Pharmacy Data system breakdown, Contractor may provide documentation to DMAP. DMAP will review Contractor's documentation before determining if Corrective Action is indicated.

**b. Timeliness Errors**

**(1) Schedule**

For the purposes of validating Pharmacy Data for Timeliness Errors, DMAP may collect and tabulate information in the DMAP Pharmacy Data system once every three months during the Contract Year, at DMAP's sole discretion, and without notice to Contractor.

**(2) Method**

**(i)** The unit of analysis is the date of service on the Pharmacy Transaction.

**(ii) Definition of Method**

**(A)** The number of Pharmacy Transactions submitted to the DMAP Pharmacy Data system with a date of service greater than 180 days from date of service until submission to DMAP is tabulated monthly.

**(B)** If the number of Pharmacy Transactions submitted over 180 days from the date of service exceeds 10% of the Pharmacy Data submitted, Corrective Action may be initiated.

**c. Resubmission Errors**

**(1) Schedule**

For the purposes of validating Pharmacy Data for Resubmission Errors, DMAP may collect and tabulate information in the DMAP Pharmacy Data system no less than once every month during the Contract Year, at DMAP's sole discretion, and without notice to Contractor.

**(2) Method**

**(i)** The unit of analysis is the number of Pharmacy Transactions that have been resubmitted.

**(ii) Definition of Method**

**(A)** The number of Pharmacy Transactions resubmitted to the DMAP Pharmacy Data system that error again, is calculated monthly.

**(B)** If the number of resubmitted Pharmacy Transactions that Error again exceeds 10% of resubmitted Pharmacy Transactions, Corrective Action may be initiated.

**d. Timeliness Errors in Resubmitted Pharmacy Data**

**(1) Schedule**

For the purposes of validating Pharmacy Data for Timeliness in Resubmitted Pharmacy Transactions, DMAP may collect and tabulate information in the DMAP Pharmacy Data system no less than once every three months during the Contract Year, at DMAP's sole discretion, and without notice to Contractor.

**(2) Method**

**(i)** The initial unit of analysis is the original Error notification date and the date of resubmitted Pharmacy Transactions as determined by the Internal Control Number (ICN), or lack of resubmission of Pharmacy Transactions by the notification date. Subsequent units of analysis are set at 63 days interval after the initial deadline date (63 days from original notification).

**(ii) Definition of Method**

**(A)** The number of Pharmacy Transactions in the DMAP Pharmacy data system with a date greater than 63 days before resubmission to DMAP, or Pharmacy Transactions that are not resubmitted to DMAP, is calculated monthly. Thereafter, the numbers of Pharmacy Transactions that remain in the DMAP Pharmacy Data system in 63-day increments are calculated until the Pharmacy Transactions Adjudicate within DMAP's system error free.

**(B)** If more than 10% of uncorrected resubmitted Pharmacy Transactions remain uncorrected for more than 63 days after original notification and initial resubmission, Corrective Action may be initiated.

## 5. Validation Methodology

DMAP may draw samples from Enrollment information and Pharmacy Data for the purpose of performing validation audits, to be consistent with the protocol for Validating Pharmacy Data, set forth by the Department of Health and Human Services, Centers for Medicare and Medicaid Services, available at: http://www.cms.hhs.gov/MedicaidManagCare/.

### a. Omission Errors

For the purpose of determining Omission Errors, the DMAP sample shall be considered final for all Pharmacy Data with dates of service 180 days or more prior to the date the sample was selected. DMAP may allow exceptions for Pharmacy Data submitted more than 180 days from the date of service as noted in Section 1, Subsection b, Paragraph (5) Items (i) through (vii) of this Schedule 4.

**(1) Schedule**

Omission Errors are not tabulated continuously as part of the Pharmacy Data system; therefore, an annual sampling of Contractor's DMAP Member medical records as provided by Contractor's Participating Provider is required in order to assess these errors. For the purposes of validating Pharmacy Data for Omission Errors, DMAP, or its designee, may collect information from Contractor's DMAP Member medical records no less than once for each Contract Year. DMAP, or its designee, shall give Contractor no less than 30 days written notice prior to reviewing or collecting information from Contractor's DMAP Member medical records. Contractor shall request and submit medical records to DMAP, or make the records available at Contractor's office, within 30 days of receiving the written request for the medical records.

**(2) Method**

**(i)** The DMAP Member's medical record is the basis of comparison.

**(ii) Definition of Method**

**(A)** For a Validation Period, the number of Pharmacy Transactions observed in the medical record sampling above, but not reported by Contractor to DMAP as Pharmacy Data, is determined and computed as a percentage. This percentage is then the Contractor's Rate of Omission Error.

**(B)** If the Omission Error rate exceeds 10% of reported Pharmacy Data, Corrective Action may be initiated.

**b. Missing Medical Records**

**(1) Schedule**

**(i)** Missing Medical Record Errors are tabulated from the samples drawn for Omission and Accuracy Errors. DMAP, or its designee, may collect information from Contractor's DMAP Member medical records as provided by Contractor's Participating Provider no less than once for each Contract Year. DMAP, or its designee, shall give Contractor no less than 30 days written notice prior to reviewing or collecting information from Contractor's DMAP Member medical records. Contractor shall request and submit medical records to DMAP, or make the records available at Contractor's office, within 30 days of receiving the written request for the medical records.

**(ii)** Upon review of the submitted medical records, DMAP staff shall notify the Contractor of missing medical records. Contractor will have the opportunity to submit these missing medical records within 30 days written notice from DMAP.

**(2) Method**

**(i)** The DMAP Member's medical record is the basis of analysis.

**(ii) Definition of Method**

**(A)** The number of medical records not submitted to DMAP within the 30-day period after receiving the second written notice may be the number of Missing Medical Record Errors.

**(B)** If medical records are missing for more than 1% of the sample drawn, Corrective Action shall be initiated as per Contract, Exhibit B, Part VI, Section 2, Subsection a, Paragraph (4).

**c. Accuracy Errors**

For the purpose of determining Accuracy Errors, DMAP will consider subsequent adjustments to Pharmacy Data, if the adjustments are made prior to the sample selection. After that time, Pharmacy Data will be considered final for the purpose of determining Accuracy Errors.

**(1) Schedule**

Accuracy Errors are not tabulated continuously as part of the Pharmacy Data system; therefore, an annual sampling of Contractor's submitted Pharmacy Data is required in order to assess these errors. DMAP, or its designee, may collect information from Contractor's DMAP Member medical records as provided by Contractor's Participating Provider to validate specific Pharmacy Data elements no less than once for each Contract Year. DMAP, or its designee, shall give Contractor no less than 30 days written notice prior to reviewing or collecting information from Contractor's DMAP Member medical records. Contractor shall request and submit medical records to DMAP or make the records available at Contractor's office within 30 days of receiving the written request for the medical records.

**(2) Method**

**(i)** Contractor's Accuracy Errors in the Pharmacy Data are computed as follows:

**(A)** The DMAP Pharmacy Data medical review team shall determine the number of errors in the test samples of Pharmacy Transactions that were reported to DMAP with one or more Accuracy Errors in the data elements. This determination shall be based on a comparison of information available in the medical record and the information reported to the DMAP Pharmacy Data system.

**(B)** A calculated percentage of Accuracy Errors determined from the test sample shall be applied to the population of the Pharmacy Data. This number shall be reduced by a 5% error tolerance adjustment.

**(C)** The result is the estimated number of Accuracy Error Pharmacy Transactions. If the Accuracy Errors exceed the 5% tolerance adjustment, Corrective Action may be initiated.

**d. Inadequate Submission Errors**

**(1) Schedule**

For the purposes of validating Pharmacy Data for Inadequate Submission Errors, DMAP may collect and tabulate information in the DMAP Pharmacy Data system during the Contract Year, at DMAP's sole discretion, and without notice to Contractor.

**(2) Method**

The rate of comparison is the number of original Pharmacy Transactions received in DMAP's Pharmacy Data system as a proportion of the total Transactions.

**(i)** DMAP staff will develop submission rates for Contractor's expected rate of Pharmacy Data submission.

**(ii)** Projections will consider factors including, but not limited to, Enrollment information, expected utilization of services and lag time for Contractor to receive Pharmacy Data information from Providers.

**(iii)** Each month DMAP will review the number of Pharmacy Transactions received from Contractor for comparison to the expected number of Pharmacy Transactions submissions from Contractor.

**(iv)** If the number of submissions of Pharmacy Transactions received by DMAP from Contractor is less than 50% of the expected number of Pharmacy Transactions submission, Corrective Action may be initiated.

## 6. Corrective Action

**a.** Previous Contract requirements will be subject to Corrective Action according to the terms of that Contract Year. Termination of the Contract does not relieve Contractor of Contractor's obligation to submit all required Pharmacy Data for dates of service within the Contract Year, nor does it relieve Contractor of the obligation to complete Corrective Action plans or pay recovery costs.

**b.** When DMAP intends to implement Corrective Action the procedures stated in Exhibit B, Part VI, Section 2, Sanctions, of this Contract shall apply.

**c.** Corrective Action may be initiated if more than 10% of the Pharmacy Transactions submitted are over 180 days of the date of service.

**d.** Contractor shall not incur additional penalties caused by errors directly related to an active Action Plan if the matter is resolved within a mutually agreed upon time frame. DMAP will initiate a revised Action Plan if new errors not directly related to the current Action Plan occur.

## SCHEDULE 5 – MCO Enrollment of Dual Eligible Clients

Contractor Name: _____

Contract Year: _____ through _____

DMAP requires Contractors that are affiliated with an entity that provides services as a Medicare Advantage plan to provide information for purposes of Disenrollment of dual eligible clients who are enrolled in the Contractor's OHP Plan and do not submit the required Medicare Advantage Plan Election Form.

Contractor shall choose whether to disenroll or maintain Enrollment for all the OHP Clients from whom they do not receive a form at the end of 30 days. This decision will cover all services areas as outlined Part V of this Contract that also coincides with Contractor's Medicare Advantage service area of Contractor or its affiliate.

The FCHP or PCO must submit this Schedule 5, notifying DMAP of Contractor's annual decision to disenroll or maintain Enrollment for the OHP Clients in accordance with OAR 410-141-0060.

This notification must be submitted by January 31 of each year, or another date specified by DMAP.

**1.** Please indicate if you are affiliated with an entity that provides a Medicare Advantage plan:

Yes _____ (if yes, please answer #2)
No _____ (if no, please disregard #2)

**2.** Indicate whether Contractor will request Disenrollment of dual eligible members who do not submit the Medicare Advantage Plan Election Form:

Yes _____
No _____

Signed _____

Title _____

Date _____