2008 OREGON HEALTH PLAN

MENTAL HEALTH ORGANIZATION AGREEMENT

[Name of Organization]

Contract Number *[xxxxxx]*

TABLE OF CONTENTS

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2008 OREGON HEALTH PLAN
Mental Health Organization Agreement

This Agreement is between the State of Oregon, acting by and through its Department of Human Services (DHS), Addictions and Mental Health Division, hereinafter referred to as AMH, and

[Name of Organization]
[Physical Address]
[City, State, Zip]

hereinafter referred to as Contractor. DHS' supervising representative for this Agreement is the AMH Medicaid Policy Unit Manager.

I. Term and Approval

A. This Agreement shall become effective January 1, 2008 or on the date at which both parties have signed this Agreement and this Agreement has been approved for legal sufficiency by the Oregon Department of Justice, whichever is later, and shall continue in effect, unless otherwise terminated or extended, through December 31, 2008. No work may be performed under this Agreement prior to its effective date.

B. If DHS wishes to amend this Agreement to extend its effectiveness beyond its current expiration date, DHS will give Contractor notice, by certified mail, of its desire to extend prior to the expiration date. DHS will provide Contractor with as much advance notice (up to 60 calendar days) as reasonably possible of its desire to extend the effectiveness of this Agreement beyond its current expiration date. Within 14 calendar days of receiving notice, Contractor shall give DHS written notice of its intent regarding extension of this Agreement. In order for any extension of this Agreement to be effective, the extension must be signed by the parties prior to the expiration of this Agreement or any extension thereof and all necessary State of Oregon approvals must be obtained, including approval by the Department of Justice, if required.

II. Agreement in its Entirety

This Agreement consists of this document together with the following exhibits and schedules, which are attached hereto and incorporated into this Agreement 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 Financial Reporting
Exhibit H: Encounter Minimum Data Set Requirement
Exhibit I: Third Party Resources and Personal Injury Liens

Exhibit J: Prevention/Detection Fraud and Abuse
Exhibit K: Mental Health Services Practitioner Report
Exhibit L: Mental Health Organization (MHO) Grievance Log
Exhibit M: Practitioner Incentive Plans
Exhibit N: MHO Grievance System
Schedule 1: Client Process Monitoring System (CPMS)
Schedule 2.1: Procedure for Long Term Care Determinations for OHP Members 18-64
Schedule 2.2: Procedure for Long Term Care Determinations for OHP Members 17 and Under
Schedule 2.3: Procedure for Long Term Care Determinations for OHP Members Requiring Geropsychiatric Treatment
Schedule 3: Oregon Patient/Resident Care System
Schedule 4: Level of Need Determination
Schedule 5: Signature Authorization Form
Schedule 5.1: Attestation of MHO Revision and Submission of Contractually Required Reporting
Schedule 6: Key Personnel

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

III. Status of Contractor

A. Type of Business:

Contractor is a intergovernmental entity organized under the laws of Oregon, which is serving as a Mental Health Organization (MHO) under this Agreement.

Contractor is not a Health Care Services Contractor as defined in ORS 750.005 (4).

Contractor is not a Federally Qualified Health Maintenance Organization registered as such with the Oregon Department of Consumer and Business Services.

B. Status of Contractor

If Contractor is a Health Care Services Contractor as defined in ORS 750.005(2), Contractor shall not provide prepaid health services on a capitated basis to any persons other than OHP Members, unless Contractor meets all statutory and regulatory requirements as a Health Care Services Contractor under ORS Chapter 750.

C. Corporate Activity

Contractor agrees to include all of its financial activities under Corporate Activity when completing Reports G.2 through G.5. Any changes to the reporting of Corporate Activity shall be approved by AMH in writing before implementation.

IV. Service Area

Contractor's designated Service Area is within ***[Name of Service Area(s)]*** County(ies). Contractor shall serve, under the terms and conditions set forth in this Agreement, Oregon Health Plan (OHP) Clients living in these counties who are enrolled with Contractor by DHS as described in Exhibit B, Part III, Section 4, Enrollment and Disenrollment, of this Agreement.

V. *(Reserved)*

VI. Contractor Information

Pursuant to Internal Revenue Service regulations, Contractors must furnish its Taxpayer Identification Number (TIN) to the State prior to Agreement approval. This information will be reported to the Internal Revenue Service (IRS) under the name and taxpayer identification number submitted. If the IRS notifies DHS any two years out of three that the name and number given do not match, Contractor could be subject to backup withholding at a rate of 31 percent.

The individual signing this Agreement on behalf of Contractor hereby certifies and swears, under penalty of perjury: (a) that the number shown below is the correct Contractor taxpayer identification number, and that Contractor is not subject to backup withholding because: (i) Contractor is exempt from backup withholding, (ii) Contractor has not been notified by the IRS that Contractor is subject to backup withholding as a result of failure to report all interest or dividends, or (iii) the IRS has notified Contractor that Contractor is no longer subject to backup withholding; (b) that s/he is authorized to act on behalf of Contractor, has authority and knowledge regarding Contractor's payment of taxes, and to the best of her/his knowledge, Contractor is not in violation of any Oregon tax laws (including, without limitation, those listed below); (c) that Contractor is an independent contractor as defined in ORS 670.600; and (d) that the information set forth in this Part VI, Contractor Information, is true and accurate. For purposes of this certificate, "Oregon tax laws" means the state inheritance tax, gift tax, personal income tax, withholding tax, corporation income and excise taxes, amusement device tax, timber taxes, cigarette tax, other tobacco tax, 9-1-1 emergency communications tax, the homeowners and renters property tax relief program and local taxes administered by the Department of Revenue (Multnomah County Business Income Tax, Lane Transit District Tax, Tri-Metropolitan District Employer Payroll Tax, and Tri-Metropolitan Transit District Self-Employment Tax).

If Contractor is not a corporation, a county or an intergovernmental entity organized under ORS Chapter 190, or is a professional corporation, then the individual signing this Agreement on behalf of Contractor must certify that Contractor is an Independent Contractor and that the Contractor meets the following standards: (a) that the Contractor is registered under ORS chapter 701 to provide labor or services for which such registration is required; (b) that the Contractor has filed federal and state income tax returns in the name of the Contractor's business or a business Schedule C as part of the personal income tax return, for previous year, or expects to file federal and state income tax returns, for labor or services performed as an independent contractor in the previous year; (c) that the Contractor will furnish the tools or equipment necessary for the contracted labor or services; (d) that the Contractor has the authority to hire and fire employees who perform the labor or services; and (e) that the Contractor represents to the public that the labor or services are to be provided by it's independently established business because four or more of the following circumstances exist: (i) the labor or services are primarily carried out at a location that is separate from the Contractor's residence or is primarily carried out in a specific portion of the Contractor's residence, which is set aside as the location of the business; (ii) commercial advertising or business cards are purchased for the business, or the Contractor has a trade association membership; (iii) telephone listing is used for the business that is separate for the personal residence listing; (iv) labor or services are performed only pursuant to written contracts; (v) labor or services are performed for two or more different persons within a period of one year; (vi) Contractor assumes financial responsibility for defective workmanship or for services not provided as evidenced by the ownership of performance bonds, warranties, errors and omission insurance or liability insurance relating to the labor or services to be provided.

By execution of this Agreement, I, an authorized official of Contractor, certify that I have read this Agreement, Exhibits, Schedules and Attachments, and have shared data reporting requirements with Contractor's computer systems personnel to assure that mechanisms are in place to provide for the collection and reporting of data as specified in this Agreement.

Agreement Number: ***[xxxxxx]***

Agreement Period: January 1, 2008 through December 31, 2008

LEGAL BUSINESS NAME: ***[Name of Organization]***
(This must match the name in which your TIN was issued)

Address: ***[physical address]***
City, State, Zip: ***[city, state, zip]***
Telephone: ***[xxx-xxx-xxxx]***
Facsimile Number: ***[xxx-xxx-xxxx]***

TAXPAYER IDENTIFICATION NUMBER: ***[xx-xxxxxxx]***
(Federal Employer Identification Number)

STATE TAX IDENTIFICATION NUMBER: Same as above

Business Designation
_____ Corporation
_____ Partnership
_____ Limited Partnership
_____ Limited Liability Company
_____ Limited Liability Partnership
_____ Sole Proprietorship
_____ Intergovernmental
_____ Government
_____ Non-Profit Corporation

VII. Interpretation and Administration of Agreement

A. In interpreting this Agreement, its terms and conditions shall be construed as much as possible to be complementary, giving preference to this Agreement, (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 listed earlier in Section II shall control. In the event that DHS needs to look outside of this Agreement, exhibits, and attachments for purposes of interpreting its terms, DHS will consider the following sources in the order 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 (OHP) Medicaid Demonstration Project), 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 OHP Medicaid Demonstration Project and the State Children's Health Insurance Program (SCHIP), Title XXI of the Social Security Act, as amended and administered in Oregon by DHS.

3. The Oregon Revised Statutes concerning the OHP.

4. Oregon Administrative Rules related to the OHP Medicaid Demonstration Project and State Children's Health Insurance Program concerning mental health Services promulgated by DHS.

5. Other applicable Oregon statutes and DHS administrative rules concerning the Medical Assistance Program under prepaid capitated plans and Fee-For-Service (FFS) arrangements.

6. Other applicable Oregon statutes and DHS administrative rules concerning mental health Services.

B. If Contractor believes that any provision of this Agreement or DHS' interpretation thereof, is in conflict with federal or state statutes or regulations, Contractor shall notify AMH in writing immediately.

Any provision of this Agreement which is in conflict with Federal Medicaid statutes, regulations, or CMS policy guidance shall be amended to conform to the provision of those laws, regulations and federal policy.

C. If Contractor disputes any interpretation, action or decision of DHS concerning this Agreement, including sanctions, recovery, or overpayment actions, Contractor may request an administrative review as described below.

1. Administrative Review

Contractor shall send the request for administrative review to the DHS Supervising Representative with a postmark within 30 calendar days of the effective date or announcement date, whichever is last, of DHS' interpretation, action or decision which prompted the administrative review request. Contractor must specify the interpretations, actions or decisions being appealed and the reason(s) for the appeal on each interpretation, action or decision. The appeal shall include any new information or descriptions of actions that will support a change of the original interpretation(s), action(s), or decision(s). Within 60 calendar days of receiving the request for an administrative review, the DHS Supervising Representative, or designee, shall do the following: determine which interpretations, actions or decisions will be reviewed; grant or deny an administrative review; notify Contractor of the date, time, and location of any applicable administrative review meeting; and issue to Contractor a written decision resulting from the administrative review, if any.

2. Contested Case Hearings

Within 30 calendar days of receiving a denial of the request for an administrative review or of receiving an administrative review decision, Contractor may make a written request for a contested case hearing.

Contractor shall send the request for a contested case hearing to the DHS Supervising Representative, or designee, with a postmark not later than 30 calendar days following the date of notice of adverse decision resulting from the administrative review process. Contested case hearings shall follow the process described in OAR 410-120-1720, Provider Appeals – Hearing Evidence, through 410-120-1820, Provider Hearings-Role of the Hearing Officer, except that such hearings shall be heard by the Hearings Officer panel or other independent hearings officer designated by DHS.

D. Contractor shall notify its Subcontractors and Participating Providers of Contractor's process for resolving issues related to this Agreement.

VIII. Government Status

Contractor certifies that it is not currently employed by the federal government to Provide the work covered by this Agreement. Contractor certifies that Contractor is not an employee of the State of Oregon. Contractor shall be responsible for any federal or state taxes applicable to Capitation Payments made under this Agreement. Contractor shall not be eligible for any benefits from contract payments of federal Social Security, unemployment insurance, or workers' compensation, except as a self-employed individual.

IX. Signatures

In witness, the parties listed below have caused this Agreement to be executed by their duly authorized officers.

Contractor:
Accountable Behavioral Health Alliance

_____ _____
[Name of Signer] Date
[Title of Signer]

DHS:
Addictions and Mental Health Division:

_____ _____
Authorized Signature Date
Assistant. Administrator
Addictions and Mental Health Division

Approved as to Legal Sufficiency:
Electronic approval by: Theodore C. Falk, Senior Assistant Attorney General, on November 15, 2007, email in Contract file.

Reviewed:

_____ _____
DHS Contracts Coordinator 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) 309-012-0140, 309-032-0535, 309-033-0210, 410-120-0000, and 410-141-0000. The order of preference for interpreting conflicting definitions is this Agreement, (following the order of precedence in Section VI.A), Oregon Health Plan Rules of DHS, General Rules of DHS, and Mental Health Rules of DHS. The following terms have the following meanings below when capitalized:

1. **Abuse:** Any death caused by other than accidental or natural means; any physical injury caused by other than accidental means or that appears to be at variance with the explanation given of the injury; willful infliction of physical pain or injury; and sexual harassment or exploitation, including but not limited to, any sexual contact between an employee of a facility or community program and an OHP Member. In residential programs, Abuse includes other intentional acts or absence of action that interfere with the mental, emotional or physical health of the resident.

2. **Action:**

   a. The denial or limited authorization of a requested Service, including the type or level of Service;

   b. reduction, suspension, or termination of a previously authorized Service;

   c. denial, in whole or in part, of payment for a Service;

   d. failure to Provide Services in a timely manner;

   e. failure to act on Grievances and Appeals within specified timeframes; or

   f. denial of a request to obtain Services outside the Provider Panel, as follows:

      (1) denial of a request to obtain Services from any other provider (in terms of training, experience, and specialization) not available within the Provider Panel;

      (2) denial of a request to obtain Services from a non-Participating Provider who is the main source of a Service to the OHP Member, provided that the provider is given the same opportunity to become a Participating Provider (and further provided that if the provider chooses not to join the Provider Panel or does not meet the qualifications, the OHP Member is given a choice of Participating Providers and is transitioned to a Participating Provider with 60 days);

      (3) denial of a request to obtain Services when Contractor or Provider does not Provide the Service because of moral or religious objection;

      (4) denial of a request for a Service when the OHP Member's Provider determines that the OHP Member needs related Services that would subject the OHP Member to unnecessary risk if received separately and not all related Services are available within the Provider Panel; or

      (5) denial of a request for a Service when AMH determines that other circumstances warrant out-of –network treatment.

3. **Acute Care:** Intensive, psychiatric services provided on a short-term basis to a person experiencing significant symptoms of a mental disorder that interfere with the person's ability to perform activities of daily living.

4. **Acute Inpatient Hospital Psychiatric Care:** Acute Care provided in a psychiatric hospital with 24-hour medical supervision.

5. **Addictions and Mental Health Division (AMH):** The program office of DHS responsible for the administration of mental health services and policy and programs for chemical dependency Prevention, intervention, and treatment services for the State of Oregon.

6. **Administrative Hearing:** A DHS hearing related to an Action, including a denial, reduction, or termination of benefits that is held when requested by the OHP Member or OHP Member Representative. A hearing may also be held when requested by an OHP Member or OHP Member Representative who believes a claim for Services was not acted upon with reasonable promptness or believes the payor took an action erroneously.

7. **AMH Representative:** The individual within the Office of Mental Health Services designated to handle Administrative Hearings requested by OHP Members or OHP Member Representative. The role of AMH Representative is described in Exhibit N, MHO Grievance System.

8. **Adult and Family Services now referred to as Children, Adults and Family Services:** Program with primary responsibility to assist poor families in meeting their basic needs and to help them become more self sufficient. To achieve these outcomes, Program provides income maintenance payments to poor families; contracts with providers for employment training and placement of eligible clients; provides payments for supportive services, such as day care and transportation; and provides eligibility determination for the OHP Medicaid Demonstration Project and State Children's Health Insurance Program.

9. **Allied Agencies:** See definition for Local and/or Regional Allied Agencies.

10. **Alternative Site:** A place where Services are provided other than the service provider's office, clinic or other regular place of business. Alternative Sites are used to assure more accessible and effective delivery of the service and include, but are not limited to, a school, community center, foster home, Nursing Home, physician's office, home or other natural Setting.

11. **Americans with Disabilities Act (ADA):** Federal law promoting the civil rights of persons with disabilities, including mental illness. The purpose of the law is "to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities and to provide clear, strong, consistent, enforceable standards addressing discrimination against individuals with disabilities." The ADA requires that accommodations be made in employment, service delivery and accessibility of facilities and services.

12. **Appeal:** A request for review of an Action, i.e., the reduction, suspension, or termination of a service, the denial or limited authorization of a requested service, or the denial, in whole or in part, of a payment for a Service.

13. **Appropriate:** The extent to which a particular procedure, treatment, test, or Service is documented to be effective, clearly indicated, not excessive, adequate in quantity, and provided in the Setting best suited to the needs of the OHP Member.

14. **Assessment:** The determination of a person's need for Covered Services. It involves the collection and evaluation of data pertinent to the person's mental history and current problem(s) obtained through interview, observation, and record review. The Assessment concludes with one of the following: (1) documentation of a DSM Diagnosis providing the clinical basis for a written Treatment Plan; or (2) a written statement that the person is not in need of Covered Services. Other disposition information such as to whom the person was referred is included in the Clinical Record.

15. **Atypical Providers**: are providers that do not Provide health care, as defined under HIPAA in Federal regulations 45 CFR Section 160.103. Taxi services, home and vehicle modifications, and respite services are examples of atypical providers reimbursed by the Medicaid program.

16. **Benchmark:** The level of performance or standard against which attainment of specific objectives is measured.

17. **Capacity:** The ability to make Covered Services available in a given geographic area relative to the size, location and unique needs of the OHP Membership within it. Indicators of Capacity may be represented as ratios between the number of Participating Providers per 1,000 OHP Members for a given geographic area (county or zip code); as ratios between the number of Participating Providers per 1,000 OHP Members; as ratios between various types of Participating Providers (psychiatrists, case managers) per a set number of OHP Members with specific diagnoses, unique characteristics and/or special needs; as ratios between the number of Participating Providers per the total of OHP Members and other patients; as a function of travel time or distance between the OHP Member's residence and the Participating Provider; as a function of waiting time for regular appointments, Urgent Care, emergency care and specialty care; as a function of office waiting time; and as a function of 24-hour care. Measurement of Capacity must consider factors such as geographic or physical barriers (mountains or rivers) which preclude access, service Utilization patterns (services being sought outside the immediate vicinity), language or cultural barriers, and needs of migrant or seasonal workers.

18. **Capitated Services:** Those Covered Services that Contractor agrees to Provide in the Statement of Work, Exhibit B, Parts I through VI, of this Agreement, in exchange for a Capitation Payment.

19. **Capitation:** A payment model which is based on prospective payment for services, irrespective of the actual amount of services provided, generally calculated on a per OHP Member per month basis.

20. **Capitation Payment:** The amount paid by DHS to Contractor on a per OHP Member per month basis in advance of and as payment for the OHP Member's actual receipt of Covered Services under this Agreement.

21. **Case Management:** Services provided to OHP Members who require assistance to ensure access to benefits and services from Local, Regional and/or State Allied Agencies or other service providers. Services provided may include: advocating for the OHP Member's treatment needs; providing assistance in obtaining entitlements based on mental or emotional Disability; referring OHP Members to needed services or supports; accessing housing or residential programs; coordinating services including educational or vocational activities; and establishing alternatives to inpatient hospital services.

22. **Case Rate:** A flat rate paid per person for a specific range of services. A Case Rate may be paid for each referral made to a provider or for each admission made to a hospital. The provider receiving the payment assumes the risk of providing all Covered Services for the full range of services for each OHP Member for whom the payment was made.

23. **CCC Chair:** A QMHP with experience in children's mental health treatment designated by the CMHP director in each county to coordinate LTPC screenings.

24. **Centers for Medicare and Medicaid Services (CMS) formerly known as Health Care Financing Administration (HCFA):** The federal agency responsible for approving the waiver request to operate the OHP Medicaid Demonstration Project.

25. **Chemical Dependency Provider:** A practitioner approved by DHS to Provide publicly funded alcohol and drug abuse Rehabilitative Services.

26. **Children, Adults and Families Services formerly referred to as Services to Children and Families:** The DHS program serving as Oregon's child welfare agency. Child protective services staff assess reports of child Abuse and neglect, work with families to try to keep children in the home, and place children in foster care or residential treatment if their need for safety and other services requires substitute care. The adoption program serves children who have been released by the courts for permanent placement.

27. **Civil Commitment:** The legal process of involuntarily placing a person, determined by the Circuit Court to be a mentally ill person as defined in ORS 426.005 (1) (d), in the custody of DHS has the sole authority to assign and place a committed person to a treatment facility. DHS has delegated this responsibility to the CMHP Director. Civil Commitment does not automatically allow for the administration of Medication without informed client consent. Additional procedures described in administrative rule must be followed before Medication can be involuntarily administered.

28. **Client Process Monitoring System (CPMS):** DHS's client information system for community based services.

29. **Clinical Reviewer:** The entity jointly chosen to resolve disagreements related to an OHP Member's need for LTPC immediately following an Acute Inpatient Hospital Psychiatric Care stay.

30. **Clinical Record:** The individual client service record. For the purpose of confidentiality, it is considered the medical record defined in ORS Chapter 179.

31. **Clinical Services Coordination:** Coordinating the access to, and provision of, services from multiple agencies according to the Treatment Plan; establishing crisis service linkages; advocating for the person's treatment needs; and providing assistance to obtaining entitlements based on mental or emotional Disability.

32. **Community Coordinating Committee (CCC):** A committee composed of representatives from the local CMHP, DHS Children, Adults and Families Services, Juvenile Court, local education district, and the AMH Child and Adolescent Mental Health Specialist.

33. **Community Coordinating Committee (CCC) Care Path Plan:** A written plan for discharge to a least restrictive appropriate Setting with specific discharge criteria. Discharge criteria are linked to resolution of symptoms and behaviors that justified admission to LTPC. The CCC Care Path Plan provides an opportunity for those parties most familiar with the treatment needs of the child to develop a care path plan.

34. **Community Emergency Service Agencies:** These include, but are not limited to, hospital emergency rooms, crisis centers, protective services of DHS Seniors and People with Disabilities Program and Children Adults and Family Services, OYA, local juvenile justice, police, homeless shelters, CMHPs, and Civil Commitment investigators.

35. **Community Mental Health Program (CMHP):** The organization of all services for persons with mental or emotional disorders and developmental disabilities operated by, or contractually affiliated with, a LMHA, operated in a specific geographic area of the state under an intergovernmental agreement or direct contract with DHS.

36. **Community Services Section (CSS):** The organizational section within AMH responsible for integrating mental health services into the OHP Medicaid Demonstration Project and State Children's Health Program.

37. **Community Standard:** Expectations for access to the health care delivery system in the OHP Member's community of residence. Except where the Community Standard is less than sufficient to ensure Quality of Care, DHS requires that the health care delivery system available to Contractor's OHP Members take into consideration the Community Standard and be adequate to meet the needs of OHP Members.

38. **Condition/Treatment Pair:** Conditions described in the ICD-9 CM and treatments described in the current version of the American Medical Association's Physicians' Current Procedural Terminology (CPT), HCPC, and BA/ECC Codes established by DHS which, when paired by the HSC, constitute the line items in the Prioritized List of Health Services. Condition/Treatment Pairs may contain many diagnoses and treatments. The pairs are listed in OAR 410-141-0520, Prioritized List of Health Services.

39. **Consultation:** Professional advice or explanation given concerning a specific OHP Member to others involved in the treatment process, including Family members, staff members of other human services agencies (such as DHS Senior and People with Disabilities Programs, DHS CAF, schools, OYA, juvenile justice) and care providers (such as Nursing Homes, foster homes, or residential care facility staff).

40. **Consumer:** An OHP Member with a mental or emotional disorder who receives Covered Services. This term is also used in reference to any person receiving services through a CMHP which are not Covered Services.

41. **Continuity of Care:** The ability to sustain services necessary for a person's treatment. Continuity of Care is a concern when an OHP Member is transferred from one service provider to another.

42. **Contractor Representative:** The individual within Contractor organization responsible for handling Grievance and Administrative Hearing issues. The role of this person is described in Exhibit N, MHO Grievance System.

43. **Covered Services:** Services included in the Capitation Payment paid to Contractor under this Agreement with respect to an OHP Member under this Agreement whenever services are Medically Appropriate for the OHP Member. Services included in the Capitation Payment are described in the State of Oregon, Oregon Health Plan Service Categories for Per Capita Costs, October 2002 through September 2003. The Capitation Payment is based on the number of Condition/Treatment Pair lines of the List of Prioritized Health Services funded by the Legislature and adopted in OAR 410-141-0520. The Covered Services described in this Agreement shall be substituted with and/or expanded to include

Flexible Services and Flexible Service Approaches identified and agreed to by Contractor, the OHP Member and, as appropriate, the Family of the OHP Member as being an efficacious alternative. Covered Services are limited in accordance with OAR 410-141-0500, Excluded Services and Limitations for OHP Clients.

44. **Credentialing:** The authorization process by which the Contractor ensures that professionals and other providers who will deliver services to OHP Members are licensed to practice, or otherwise qualified for their respective positions. Authorization is determined by comparison of practitioner qualifications with applicable requirements for education, licensure, professional standing, experience, service availability and accessibility, and conformance with Contractor Utilization and quality management requirements.

45. **Culturally Competent:** The Capacity to Provide services in an effective manner that is sensitive to the culture, race, ethnicity, language and other differences of an individual. Such services may include, but are not limited to, use of bilingual and bicultural staff, provision of services in culturally appropriate alternative settings, and use of bicultural Paraprofessionals as intermediaries with professional staff.

46. **Current Procedural Terminology (CPT):** A listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians. The purpose of the terminology is to provide a uniform language that accurately describes medical, surgical, and diagnostic services, and thereby provides an effective means for reliable nationwide communication among physicians, patients, and third parties.

47. **Declaration for Mental Health Treatment:** A written statement of a person's decisions concerning his or her mental health treatment. The declaration is made when the person is able to understand and make decisions related to such treatment. It is honored when the person is unable to make such decisions.

48. **"Department 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 Agreement or in rule, it shall mean the Division of Medical Assistance Programs or DMAP. Wherever the former Office of Mental Health and Addiction Services or OMHAS is used in this Agreement or in rule, it shall mean the Addictions and Mental Health Division or AMH. Where the former Seniors and People with Disabilities or SPD is used in this Agreement or in rule, it shall mean the Seniors and People with Disabilities Division or SPD. Where the former Children, Adults and Families or CAF is used in this Agreement or rule, it shall mean the Children, Adults and Families Division (CAF). Where the former Health Division is used in this Agreement or in rule, it shall mean the Public Health Division (PHD).

49. **Diagnosis or DSM Diagnosis:** The principal mental disorder listed in the most recently published edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), that is the Medically Appropriate reason for clinical care and the main focus of treatment for an OHP Member. The Principal Diagnosis is determined through the mental health Assessment and any examinations, tests, procedures, or Consultations suggested by the Assessment. Neither a DSM "V" code disorder, substance use disorder or mental retardation may be considered the Principal Diagnosis, although these conditions or disorders may co-occur with the diagnosable mental disorder.

50. **Disabling Condition:** A physical or mental impairment that substantially limits one or more major life activities (such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working) It includes a record of having such an impairment or being regarded as having such an impairment.

51. **Disability:** A physical or mental impairment that substantially limits one or more major life activities (such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working). It includes a record of having such an impairment or being regarded as having such an impairment.

52. **Disenrollment:** The act of discharging an OHP Member from a Contractor's responsibility under the OHP. After the effective date of Disenrollment an OHP Client is no longer required to obtain Covered Services from the Contractor, nor be referred by the Contractor.

53. **Division of Medical Assistance Programs (DMAP):** The DHS program responsible for coordinating the Medical Assistance Program for the State of Oregon.

54. **DSM Code:** The numerical code, including modifiers, which identifies psychiatric disorders defined in the most recent American Psychiatric Association's Diagnostic and Statistical Manual.

55. **Early Intervention:** Provision of Covered Services directed at preventing or ameliorating a mental disorder or potential disorder during the earliest stages of onset or prior to onset for individuals at high risk of a mental disorder.

56. **Emergency Psychiatric Hold:** Pursuant to ORS Chapter 426, physical retention of a person taken into custody by a peace officer, health care facility, OSH, hospital or nonhospital facility as ordered by a physician or a CMHP director.

57. **Emergency Response System:** The coordinated method of triaging the mental health service needs of OHP Members and providing Covered Services when needed. The system operates 24-hours a day, 7-days a week and includes, but is not limited to, after hours on call staff, telephone and in person screening, Outreach, and networking with hospital emergency rooms and police.

58. **Emergency Service:** Inpatient or outpatient Covered Services by a Provider that is qualified to Provide these Services and that are needed to evaluate or stabilize an Emergency Situation. See definition for Twenty-four (24) Hour Urgent and Emergency Services.

59. **Emergency Situation:** A mental health condition manifesting itself by acute symptoms of sufficient severity such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (1) serious jeopardy to the health of the OHP Member, (2) serious impairment of bodily function, or (3) 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.

60. **Encounter:** An outpatient contact or Acute Inpatient Hospital Psychiatric Care admission for Covered Services provided to an OHP Member.

61. **Encounter Data System:** An automated information system which is maintained by DHS and includes data submitted by Prepaid Health Plans (PHP) for OHP Members receiving Covered Services. The data set resembles a "claims" data set in order to use existing or familiar data sets such as the CMS-1500, UB-92, and OMAP 501-D. Encounter data is often referred to as "dummy claims," "pseudo claims," "shadow claims," or "encounter claims."

62. **Encounter Minimum Data Set:** Reporting of OHP Member contacts using the National Standard Format (also known as CMS-1500) for outpatient services and the UB-92 format for Acute Inpatient Hospital Psychiatric Care services for OHP Member specific Covered Services.

63. **Enhanced Care Services:** Services, which are not Covered Services, defined in OAR 309-032-720 through 309-032-830 as provided to eligible persons who reside at facilities licensed by Senior and Disabled Services now referred to as Seniors and People with Disabilities Division.

64. **Enrollee:** Medicaid recipient who is currently enrolled in an MCO, PIHP or PCCM in a given managed care program.

65. **Enrollment:** The assignment of OHP Clients to Contractors per OAR 410-141-0060, Oregon Health Plan Managed Care Enrollment Requirements. Once the OHP Client becomes an OHP Member, the person must receive all Covered Services from the Contractor or be referred by the Contractor to Mental Health Practitioners.

66. **Evaluation:** A psychiatric or psychological Assessment used to determine the need for mental health services. The Evaluation includes the collection and analysis of pertinent biopsychosocial information through interview, observation, and psychological and neuropsychological testing. The Evaluation concludes with a five axes Diagnosis of a DSM multiaxial Diagnosis, prognosis for rehabilitation, and treatment recommendations.

67. **Extended Care Management:** Overseeing the Utilization of extended care resources.

68. **Extended Care Management Unit (ECMU):** The unit within AMH responsible for providing the clinical Assessment, Consultation, and placement of adults age 18 to 64 with severe and persistent mental illness who require long term structure, support, rehabilitation, and supervision within designated Extended Care Projects; the Utilization review of those projects and the screening of all requests for admission to LTPC.

69. **Extended Care Project:** State-funded program designed to Provide necessary services for adults in a least restrictive environment, utilizing a range of hospital, residential, and community resources. These programs include secure residential facilities, residential psychiatric treatment, Post Acute Intermediate Treatment Services (PAITS) programs, Geropsychiatric Treatment Program at OSH, DHS Seniors and People with Disabilities Program enhanced care and PASSAGES Projects, "365" Plans, Psychiatric/Vocational Projects and enhanced foster care programs.

70. **Extended Medication Adjustment:** Regulation and adjustment of Medications lasting more than 21 to 28 days due to significant complications arising from severe side effects of Medications.

71. **Family:** Parent or parents, legal guardian, siblings, grandparents, spouse and other primary relations whether by blood, adoption, legal or social relationship.

72. **Fee-For-Service (FFS):** The payment for reimbursable services retrospectively based upon agreed rates and the amount of service provided.

73. **Flexible Service:** A service that is an alternative or addition to a Traditional Service that is as likely or more likely to effectively treat the mental disorder as documented in the OHP Member's Clinical Record. Flexible Services may include, but are not limited to: Respite Care, Partial Hospitalization, Subacute Psychiatric Care, Family Support Services, Parent Psychosocial Skills Development, Peer Counseling, and other non-Traditional Services identified.

74. **Flexible Service Approach:** The delivery of any Covered Service in a manner or place different from the traditional manner or place of service delivery. A Flexible Service Approach may include delivering Covered Services at Alternative Sites such as schools, residential facilities, nursing facilities, OHP Members' homes, emergency rooms, offices of DHS, other community settings; offering flexible clinic hours; offering Covered Services through Outreach or a Home-Based Approach; and using Peers, Paraprofessionals and persons who are Culturally Competent to engage difficult-to-reach OHP Members.

75. **Fully Capitated Health Plans (FCHPs):** PHPs that contract with DHS to Provide physical health care services under the OHP Medicaid Demonstration Project and SCHIP.

76. **Geropsychiatric Treatment Service (OSH-GTS):** Four units at OSH serving frail elderly persons with mental disorders, head trauma, advanced dementia, and/or concurrent medical conditions who cannot be served in community programs.

77. **Good Cause:** For purposes of this Agreement, Good Cause shall mean that there were circumstances beyond the control of the OHP Member which prevented a timely Grievance filing, timely Administrative Hearing request, or timely request for benefit continuation pending resolution of the Grievance or Administrative Hearing issue.

78. **Grievance:** An oral or written communication, submitted by an OHP Member or an OHP Member Representative, which addresses issues with any aspect, other than an Action, of the Contractor's or Provider's operations, activities, or behavior that pertains to the availability, delivery, or Quality of Care including Utilization review decisions that the OHP Member believes to be adverse. The expression may be in whatever form or communication or language that is used by the OHP Member or the OHP Member Representative, but must state the reason for the dissatisfaction and the OHP Member's desired resolution.

79. **Health Care Professional:** 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), osteopathic physicians, psychologists, registered nurses, nurse practitioners, licensed practical nurses, certified medical assistants, licensed physician assistants, QMHAs, QMHPs, dentists, dental hygienists, denturists, and certified dental assistants.

80. **Health Services Commission (HSC):** The governing body responsible for the OHP Medicaid Demonstration Project and SCHIP Prioritized List of Health Services. The HSC determines the Condition/Treatment Pairs to be included on the Prioritized List of Health Services and determines the ranking of each pair.

81. **Hearing Officer:** An individual designated by DHS to conduct a hearing on DHS' behalf. The role of the Hearing Officer is described in Exhibit N, MHO Grievance System.

82. **Home-Based Approach:** Providing a service in the OHP Member's home or place of residence.

83. **Incurred But Not Reported (IBNR) Expenses:** Expenses for services authorized by an agency responsible for their payment, but for which no statement has yet been received by that agency. These are expenses for which the agency is liable and which the agency will need to expect to pay.

84. **Insolvency:** Unable to meet debts or discharge liabilities.

85. **Intake:** The process of gathering preliminary information about a potential Consumer to determine whether the person is eligible for services, the urgency of the situation or need for services, and the initial provisional Diagnosis. This information is used to schedule the first appointment, if applicable.

86. **Integrated Services Array (ISA):** The ISA is a range of service components that are coordinated, comprehensive, Culturally Competent, and include intensive and individualized home and community-based services for children and adolescents with severe mental or emotional disorders whose needs have not been adequately addressed in traditional Settings. The ISA integrates inpatient, psychiatric residential and Psychiatric Day Treatment and community-based care provided in a way to ensure that children and adolescents are served in the most natural environment possible and that the use of institutional care is minimized. The intensity, frequency, and blend of these services are based on the mental health needs of the child.

87. **Intensive Psychiatric Rehabilitation:** The application of concentrated and exhaustive treatment for the purpose of restoring a person to a former state of mental functioning.

88. **International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM):** The numerical coding system that precisely delineates the clinical picture of each patient.

89. **Interpreter Services:** Language translation services to assist non-English speaking persons to receive information and communicate when such information and communication is otherwise available only in English. Interpreter Services also include sign language service to persons with hearing impairments.

90. **Involuntary Psychiatric Care:** Any psychiatric service, such as forced Medication, which is provided on a basis other than by informed client (or guardian) consent. Involuntary psychiatric services are provided only when authorized by ORS Chapter 426 and in accordance with administrative rules. Generally, a person must be determined to lack the capacity to give informed client consent before involuntary psychiatric services may be administered.

91. **JCAHO:** The Joint Commission on Accreditation of Healthcare Organizations.

92. **JCAHO Psychiatric Residential Program:** A program which provides non-emergency inpatient (residential) psychiatric services for children under age 21 in residential facilities which are licensed by DHS Children, Adults and Families Program and accredited by the JCAHO. These programs must meet Psychiatric Day Treatment standards regarding staffing credentials and staffing patterns, the integration of education and treatment, and Family focused, community-based treatment.

93. **Licensed Medical Practitioner (LMP):** A person who is a physician, nurse practitioner or physician's assistant licensed to practice in the State of Oregon whose training, experience and competence demonstrates the ability to conduct a comprehensive mental health Assessment and Provide Medication Management. The LMHA or Contractor must document that the person meets these minimum qualifications.

94. **Local Mental Health Authority (LMHA):** As defined in ORS 430.630, the county court or board of commissioners of one or more counties who choose to operate a CMHP; or, if the county declines to operate or contract for all or part of a CMHP, the board of directors of a public or private corporation which contracts with DHS to operate a CMHP for that county.

95. **Local and/or Regional Allied Agencies:** These include, but are not limited to, LMHA, CMHPs, DHS Children, Adults and Families Division, Area Agencies on Aging, Commission on Children and Families, Department of Corrections, DHS Seniors and People with Disabilities Division , OYA, DHS

Rehabilitation Services under the Community Services Program, housing authorities, local schools, special education, law enforcement agencies, adult criminal justice and juvenile justice, developmental disability services, Chemical Dependency Providers, residential providers, Oregon State Hospital, and Prepaid Health Plans.

96. **Long-Term Psychiatric Care (LTPC):** Inpatient psychiatric services delivered in an Oregon State operated Hospital after Usual and Customary care has been provided in an Acute Inpatient Hospital Psychiatric Care Setting or JCAHO Residential Psychiatric Treatment Center for children under age 18 and the individual continues to require a hospital level of care.

97. **Marketing Materials:** Any medium produced by, or on behalf of, a PHP that can reasonably be interpreted as intended for Marketing as defined in OAR 410-141-0000.

98. **Measurable Objective:** A predetermined statement of a desired and quantifiable outcome.

99. **Medicaid:** A federal and state funded portion of the Medical Assistance Program established by Title XIX of the Social Security Act, as amended, and administered in Oregon by DHS. The program provides medical assistance to poor and indigent persons.

100. **Medicaid Authorization Specialist (MAS):** A QMHP designated at the county or regional level to determine the rehabilitative mental health needs of children in state custody referred for certain residential programs or OHP Members under age 18 requiring services which are not Covered Services.

101. **Medical Assistance Program:** A DHS program for payment of medical and remedial care provided to eligible Oregonians that is administered by identified programs, services, and operations within DHS. DHS has primary responsibility for coordinating the Medical Assistance Program.

102. **Medical Transportation:** A service provided to Medicaid-eligible persons pursuant to rules (OAR 410-136-0020 et. seq.) promulgated by DHS and published in its Medical Transportation Services Guide.

103. **Medically Appropriate:** Services and supplies which are required for Prevention (including preventing a relapse), Diagnosis or Treatment of mental disorders and which are Appropriate and consistent with the Diagnosis; consistent with treating the symptoms of a mental illness or treatment of a mental disorder; appropriate with regard to standards of good practice and generally recognized by the relevant scientific community as effective; not solely for the convenience of the OHP Member or provider of the service or supply; and the most cost effective of the alternative levels of Covered Services or supplies which can be safely and effectively provided to the OHP Member in Contractor's judgement.

104. **Medication:** Any drug, chemical, compound, suspension or preparation in suitable form for use as a curative or remedial substance taken either internally or externally.

105. **Medication Override Procedure:** The administration of psychotropic Medications to a person in an Acute Inpatient Hospital Psychiatric Care Setting when the person has refused to accept the administration of such Medications on a voluntary basis. Administration of such Medications is considered a significant procedure. Significant procedures can only be performed after the person has been committed and only when there is good cause. A Medication Override Procedure must meet the requirements of OAR 309-033-0640, Involuntary Administration of Significant Procedures to a Committed Person with Good Cause. These procedures are used as a way to administer treatment to an OHP Member who is incapable of providing informed consent and is in need of Treatment.

106. Mental Health Information System (MHIS): The information system of DHS that includes the CPMS for community based services and the OP/RCS for inpatient and acute services. It provides a statewide client registry and Contractor registry for tracking service Utilization and Contractor Capacity.

107. Mental Health Organization (MHO): A PHP under contract with DHS to Provide Covered Services under the OHP Medicaid Demonstration Project and SCHIP. MHOs can be FCHPs, CMHPs or private MHOs or combinations thereof.

108. Mental Health Practitioner: Persons with current and appropriate licensure, certification, or accreditation in a mental health profession, which include but are not limited to: psychiatrists, psychologists, registered psychiatric nurses, QMHAs, and QMHPs.

109. Multi-Family Treatment Group: The planned Treatment of mental health needs identified in the mental health Assessment which occurs in a group Setting of at least three children (none of whom are siblings, step-siblings, or live in the same household) and their families. Groups are of limited duration and designed for children and families dealing with similar issues.

110. National Provider Identifier (NPI): 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.

111. Notice of Action: A written document issued to the OHP Member when a Service, benefit, request for service authorization, or request for claim payment is denied. The Notice of Action includes the following elements: (a) a statement of the Action, the effective date of such Action, and the date the Notice of Action is mailed; (b) the reasons for the Action and the specific regulations that support the Action; (c) an explanation of the right to file a Grievance with Contractor and to request an Administrative Hearing with DHS, and the consequences of choices made; (d) a statement referring the OHP Member to an enclosed informational notice of Grievance process form; (e) a statement referring the OHP Member to an enclosed informational notice of Hearing rights form; and (f) the name and telephone number of a person to contact for additional information.

112. Notice of Intended Remedial Action: A written document issued to Contractor when AMH intends to take Remedial Action. The Notice of Intended Remedial Action includes the following elements: (a) a statement of the intended Remedial Action, the effective date of such intended Remedial Action, and the date the Notice of Intended Remedial Action is mailed; (b) the reasons for the intended Remedial Action; (c) an explanation of Contractor's right to request an administrative review as described in Part VII, Section C, Interpretation and Administration of Agreement; (d) an explanation that the intended Remedial Action will be suspended when Contractor requests an administrative review before the effective date of the intended Remedial Action and such request also includes a request to suspend the intended Remedial Action until a decision is reached through the administrative review process; (e) an explanation that if the intended Remedial Action is suspended as described above in (d) and a decision is reached in favor of DHS, the intended Remedial Action may be imposed retroactively to effective date stated in the Notice of Intended Remedial Action; and (f) in cases where the Remedial Action includes withholding of Capitation Payments because Contractor has failed to Provide Covered Services and/or DHS has incurred costs in providing Covered Services, a list of OHP Members for whom Capitation Payments will be withheld, the nature of the Covered Services denied by Contractor, and costs incurred by DHS in providing Covered Services in accordance with this Agreement.

113. **Nursing Home or Nursing Facility:** An establishment with permanent facilities for the comprehensive care of persons who require assistance with activities of daily living and 24-hour nursing care. Nursing services exclude surgical procedures and include complex nursing tasks that cannot be delegated to an unlicensed person. A Nursing Facility is licensed and operated pursuant to Oregon Revised Statute 441.020(2).

114. **OHP Member:** As used in this Agreement, an individual found eligible by a program of DHS to receive health care services under the OHP Medicaid Demonstration Project or SCHIP and who is enrolled with Contractor under this Agreement.

115. **OHP Member Representative:** A person who can make OHP related decisions for OHP Members who are not able to make such decisions themselves. An OHP Member Representative may be, in the following order of priority, a person who is designated as the OHP Member's health care representative, a court-appointed guardian, a spouse, or other Family member as designated by the OHP Member, the Individual Service Plan Team (for OHP Members with developmental disabilities), parent or legal guardian of a minor below the age of consent, a DHS case manager or other DHS designee. For OHP Members in the care or custody of DHS' Children, Adults and Families Services or OYA, the OHP Member Representative is DHS or OYA. For OHP Members placed by DHS through a Voluntary Child Placement Agreement (SCF form 499), the OHP Member shall be represented by his or her parent or legal guardian.

116. **Oregon Health Plan (OHP):** Oregon's health care reform effort consisting of a Medicaid Demonstration Project, SCHIP, an individual insurance program for persons excluded from health insurance coverage due to pre-existing health conditions, and a group insurance program for small businesses. One objective of this reform effort includes universal coverage for Oregonians. In the context of this Agreement, OHP refers to the OHP Medicaid Demonstration Project and SCHIP.

117. **Oregon Health Plan (OHP) Client:** An individual found eligible by a program of DHS to receive health care services under the OHP Medicaid Demonstration Project or State Children's Health Insurance Program.

118. **Oregon Health Plan (OHP) Medicaid Demonstration Project:** The project which expands Medicaid eligibility to Oregon residents with three components, OHP Plus, OHP Standard, and Family Health Insurance Assistance Program. The OHP Medicaid Demonstration Project 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.

119. **OHP Plus Benefit Package:** A benefit package with a comprehensive range of Services, as described in OAR 410-120-1200, Medical Assistance Benefits, available to OHP Members who are over the age of 65, the disabled, the TANF population, General Assistance recipients, and pregnant women and children (under the age of 19) up to 185 percent of Federal Poverty Level (FPL).

120. **OHP Standard Benefit Package:** A benefit package that provides basic health care Services as described in OAR 410-141-0050 and OAR 410-141-1200, Medical Assistance Benefits, for adults who are not otherwise eligible for Medicaid (Families, Adults, Adults/Couples).

121. **Oregon Patient/Resident Care System (OP/RCS):** DHS data system for persons receiving services in the Oregon State Hospitals and selected community hospitals providing Acute Inpatient Hospital Psychiatric services under contract with DHS.

122. **Oregon State Hospital (OSH):** The state-operated psychiatric hospital with campuses in Salem and Portland, and the state-operated psychiatric hospital in Pendleton.

123. **Oregon Youth Authority (OYA):** The Department created by the 1995 Legislative Assembly that has responsibility for care and housing of child and adolescent offenders adjudicated and sentenced by juvenile justice to the juvenile correction system.

124. **Other Inpatient Services:** Services which are equivalent to Acute Inpatient Hospital Psychiatric Care but which are provided in a non-hospital Setting.

125. **Outpatient Hospital Services:** Covered Services received in an outpatient hospital Setting where the OHP Member has not been admitted to the facility as an inpatient, as defined in the DHS Hospital Services Guide.

126. **Outreach:** Services provided away from the service provider's office, clinic or other place of business in an effort to identify or serve OHP Members who might not otherwise obtain, keep or benefit from usual appointments. Such services include, but are not limited to, community-based visits with an OHP Member in an attempt to engage him or her in Medically Appropriate treatment, and providing Medically Appropriate treatment in a Setting more natural or comfortable for the OHP Member.

127. **Paraprofessional:** A worker who does not meet the definition of QMHA or QMHP but who assists such associates and professionals.

128. **Parent Psychosocial Skills Development:** Theoretically based interventions that focus on developing and strengthening a parent's competencies in areas of functioning such as skills in managing stress and reducing anger.

129. **Participating Provider:** An individual, facility, corporate entity, or other organization which provides Covered Services under an agreement with Contractor and agrees to bill in accordance with such agreement. For Contractors who utilize a staff model and/or Provide Covered Services directly, a Participating Provider may also include employees of Contractor.

130. **PASSAGES Projects:** One type of Extended Care Project which consists of community-based services for adults with severe and persistent mental illness who have been hospitalized for over six months in an Oregon State Hospital or who have had difficulty maintaining stability in other structured community Settings. Placements in these projects are approved by the AMH ECMU.

131. **Peer:** A person who has equal standing with another as in gender, socio-economic status, age or mental disorder.

132. **Peer Counseling:** A mental health service or support provided by trained persons with characteristics similar to the Consumer such as persons in recovery from a major mental illness or persons representing a generational cohort or persons with the same cultural background.

133. **Personal Care in Adult Foster Homes:** Medicaid-covered activities of daily living and support services provided in a licensed Family home or other home for five or fewer persons who are unable to live by themselves without supervision according to standards and procedures defined in OAR 309-040-0000 through 309-040-0100.

134. **Post-Stabilization:** Covered Services related to an Emergency Situation that are provided after an Enrollee is stabilized in order to maintain the stabilized condition, or to improve or resolve the Enrollee's condition.

135. **Potential Enrollee:** 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.

136. **Preadmission Screening and Resident Review (PASRR):** Screening and Evaluation services for residents of licensed nursing facilities to determine their need for inpatient psychiatric hospitalization according to federal standards and procedures defined in OAR 309-048-0050 through 309-048-0130.

137. **Prepaid Health Plan (PHP):** A managed care organization that contracts with DHS on a case managed, prepaid, capitated basis under the OHP Medicaid Demonstration Project and SCHIP. PHPs may be Dental Care Organizations (DCO), FCHPs, Chemical Dependency Organizations (CDO), or MHO.

138. **Prevention:** Services provided to stop, lessen or ameliorate the occurrence of mental disorders.

139. **Primary Care Practitioner (PCP):** A general practice physician, Family physician, general internist, pediatrician, or gynecologist who is responsible for providing and coordinating the OHP Member's health care services. This person authorizes referrals to specialists and payment is contingent upon these authorizations.

140. **Principal Diagnosis:** The reason that is chiefly responsible for the visit. See DSM, Use of the Manual, page 3.

141. **Prioritized List of Health Services:** The listing of Condition/Treatment Pairs developed by the HSC for the purpose of implementing the OHP Medicaid Demonstration Project. See OAR 410-141-0520, Prioritized List of Health Services, for the listing of Condition/Treatment Pairs.

142. **Provide:** To furnish directly, or authorize and pay for the furnishing of, a Covered Service to an OHP Member.

143. **Provider:** An organization, agency or individual licensed, certified or authorized by law to render professional health services to OHP Members.

144. **Provider Panel:** Those Participating Providers affiliated with the Contractor who are authorized to Provide services to OHP Members.

145. **Provider Taxonomy Codes:** are 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.

146. **Psychiatric Day Treatment:** Community-based day or residential treatment services for children in a psychiatric treatment Setting which conforms to established state-approved standards.

147. **Psychiatric Rehabilitation:** The application of treatment for the purpose of restoring a person to a former or desired state of overall functioning. See definition of Intensive Psychiatric Rehabilitation.

148. **Psychiatric Security Review Board (PSRB):** The Board authorized under ORS Chapter 161 which has jurisdiction over persons who are charged with a crime and found guilty except for insanity.

149. **Psychiatric Vocational Project:** One type of Extended Care Project which includes two community-based projects jointly funded by DHS Rehabilitation Services under the Community Services Program and AMH. These two projects, Bridges in Washington County and Laurel Hill in Eugene, Provide Intensive Psychiatric Rehabilitation Services with a vocational emphasis. Placement in these projects is approved by the AMH ECMU.

150. **Psychoeducational Program:** Training conducted for the purpose of creating an awareness of mental disorders and Treatment.

151. **Qualified Mental Health Associate (QMHA):** A person delivering services under the direct supervision of a QMHP and meeting the following minimum qualifications as documented by Contractor: a bachelor's degree in a behavioral sciences field; or a combination of at least three years' relevant work, education, training or experience; and has the competencies necessary to communicate effectively; understand mental health Assessment, treatment and service terminology and to apply the concepts; and Provide psychosocial Skills Development and to implement interventions prescribed on a Treatment Plan within their scope of practice.

152. **Qualified Mental Health Professional (QMHP):** A LMP or any other person meeting the following minimum qualifications as documented by Contractor: graduate degree in psychology; bachelor's degree in nursing and licensed by the State of Oregon; graduate degree in social work; graduate degree in behavioral science field; graduate degree in recreational, art, or music therapy; or bachelor's degree in occupational therapy and licensed by the State of Oregon; and whose education and experience demonstrates the competencies to identify precipitating events; gather histories of mental and physical disabilities, alcohol and drug use, past mental health services and criminal justice contacts; assess Family, social and work relationships; conduct a mental status examination; document a multiaxial DSM Diagnosis; write and supervise a Treatment Plan; conduct a Comprehensive Mental Health Assessment; and Provide Individual Therapy, Family Therapy, and/or Group Therapy within the scope of their training.

153. **Quality Assessment (QA):** The measurement of both the technical and interpersonal aspects of care (process) and the outcomes of that care. As such, it is the first step in Quality Assurance and improvement. It does not move beyond problem detection and measurement (IOM 1990).

154. **Quality Assurance:** A full cycle of activities for measuring Quality of Care and maintaining it at acceptable levels.

155. **Quality Assessment/Performance Improvement (QA/PI) Plan:** A program that includes the basic elements as described in 42 CRF 438.240.

156. **Quality Improvement (QI):** Improvement in the performance of the process of health care and service delivery, rather than eliminating only low performing outliers. QI employs a cyclical set of activities involving continuous planning, doing, checking and action (IOM 1990).

157. **Quality of Care:** The degree to which services produce desired health outcomes and satisfaction of Consumers, and are consistent with current best practices.

158. **Reasonable Accommodation:** Consistent with the ADA and Section 504 of the Rehabilitation Act of 1973, a modification to policies, practices, or procedures when the modification is necessary to avoid discrimination on the basis of Disability unless the service provider can demonstrate that making the modification would fundamentally alter the nature of the service, program or activity. Reasonable Accommodations may include, but are not limited to, activities such as the following: (1) reading, or

providing a tape of, material otherwise provided in written format to a person with a visual impairment; (2) providing a service in a more accessible location for a person with a mobility and other impairment; (3) providing assistance to a person with a Disability in completing applications and other paperwork necessary to receipt of services; and (4) modifying a waiting area layout to accommodate a person in a wheelchair.

159. **Recoup:** To deduct or withhold (part of something due) for an equitable reason. Recoupment occurs as a deduction on the next month's Capitation Payment and is reflected on the Remittance Advice. Types of actions that can trigger a recoupment include mid-month OHP Member out of Service Area moves, change of PHPs, and retroactive Disenrollment actions.

160. **Rehabilitative Services:** Rehabilitative Services are any Medically Appropriate remedial services for the maximum reduction of a mental disability and attainment by the covered individual of his/her best possible functional level.

161. **Reinsurance:** To insure by contracting to transfer in whole or in part a risk or contingent liability already covered under an existing contract.

162. **Remedial Action:** An action taken by AMH when, in its sole judgement, it determines that Contractor is out of compliance with this Agreement. A Remedial Action includes one or more of the following actions: suspension of Enrollment of new OHP Members, reduction of the number of OHP Members, or withholding of a portion of Capitation Payments. A Remedial Action continues until such time as AMH determines that Contractor is in compliance with this Agreement and AMH has recovered all costs incurred in the provision of Covered Services required by this Agreement.

163. **Residential/Medical Youth Care Residential Center:** A facility providing Treatment under a physician approved plan to children and adolescents (ages 3 through 20) with a mental or emotional disorder as identified in a mental health Assessment. These children and adolescents are placed by OYA or DHS Children, Adults and Families Services in cooperation with the county mental health authority. Adolescents receiving this service have a DSM, Axis I Diagnosis and reside in a DHS licensed youth care center. This service includes an Appropriate mix and intensity of individual and group therapies and Skills Development to reduce or eliminate the symptoms of the disorder and restore the individual's ability to function, to the best possible level, in home, school and community settings.

164. **Residential Service:** The organization of services in a home or facility including room, board, care and other services provided to adults assessed to be in need of such services. Residential Services include, but are not limited to, Residential Care Facilities, Residential Treatment Facilities, Residential Treatment Homes, Crisis Respite Services and Secure Residential Treatment Facilities. Residential Services do not include Supported Housing programs.

165. **Residential Treatment Facility:** A facility that is operated to Provide supervision, care and treatment on a 24-hour basis for six or more residents consistent with ORS 443.400 through ORS 443.455.

166. **Residential Treatment Home:** A home that is operated to Provide supervision, care and treatment on a 24-hour basis for five or fewer residents consistent with ORS 443.400 through ORS 443.455.

167. **Restricted Reserve Fund:** A fund that is separate from ongoing operation accounts and is limited for use to prevent Insolvency. This fund is set up to meet unexpected cash needs and to cover debts when an organization discontinues its role as a Contractor. This fund may not be used to meet expected ongoing obligations such as withholds, incentive payments and the like.

168. **Secure Adolescent Inpatient Program (SAIP):** Services Provided in an appropriately certified facility designated by AMH as LTPC, for adolescents, age 14 through 17, determined by the AMH Child and Adolescent Mental Health Specialist to be appropriate for LTPC.

169. **Secure Children's Inpatient Program (SCIP):** Services Provided in an appropriately certified facility designated by AMH as LTPC, for children, age 13 and under, determined by the AMH Child and Adolescent Mental Health Specialist to be appropriate for LTPC.

170. **Service:** The care, treatment, Service Coordination or other assistance provided to an OHP Member.

171. **Service Area:** The geographic area in which Contractor is responsible for delivering Covered Services under this Agreement.

172. **Services Coordination:** Services provided to OHP Members who require access to and/or receive services from one or more Local and/or Regional Allied Agencies or program components according to the Treatment Plan. Services provided may include establishing precommitment service linkages; advocating for treatment needs; and providing assistance in obtaining entitlements based on mental or emotional Disability.

173. **Setting:** The locations at which Covered Services are provided. Settings include such locations as mental health offices, an individual's home or school or other identified locations.

174. **Skills Training:** A program of rehabilitation as prescribed in the Treatment Plan which is designed to improve social functioning in areas important to maintaining or re-establishing residency in community, such as money management, nutrition, food preparation, community awareness, and community mobility. Skills Training can be provided on an individual basis or in a group Setting.

175. **Special Health Care Needs:** Individuals who either 1) have functional disabilities, or 2) live with health or social conditions that place them at risk of developing functional disabilities (for example, serious chronic illnesses, or certain environmental risk factors such as homelessness or family problems that lead to the need for placement in foster care.

176. **Specialized Medication Adjustment:** Medication adjustments that because of the complexity or danger, require a level of expertise beyond that of the usual LMP for that setting or client.

177. **Stabilization and Transition Services (STS):** Services Provided in an appropriately certified facility designated by AMH as LTPC for children and adolescents under age 17 determined by the AMH Child and Adolescent Mental Health Specialist to be Appropriate for LTPC, but who can be served in an enhanced short term treatment Setting.

178. **Stakeholders:** Persons, organizations and groups with an interest in how Covered Services are delivered under the MHO Agreement. Stakeholders may include, but are not limited to, OHP Members, Consumers, Families, Local and/or Regional Allied Agencies, child psychiatrists, child advocates, advocacy groups, and other groups.

179. **State Children's Health Insurance Program (SCHIP):** A federal and State funded portion of the Medical Assistance Program established by Title XXI of the Social Security Act, as amended, administered in Oregon by the Department of Human Services.

180. **State Hospital:** State-operated psychiatric hospitals including OSH in Salem and Portland, and Eastern Oregon Psychiatric Center in Pendleton.

181. **Stop Loss Coverage:** Insurance to provide excess loss coverage protection for catastrophic claims to an agency or provider.

182. **Stop Loss Protection:** Provider excess loss coverage for catastrophic claims.

183. **Subacute Psychiatric Care:** Care characterized by the commitment of treatment resources toward the resolution or amelioration of a significant, but not serious, mental health problem over a relatively short period of time.

184. **Subcontractor:** An individual, facility, corporate entity, or other organization which provides Covered Services under an agreement with Contractor and agrees to bill in accordance with such agreement.

185. **Supported Housing:** Provision of mental health rehabilitation services in the home or other community Setting for the purpose of assisting a person to live independently. Such services typically include skill development in money management, nutrition, and community living; assistance with health issues and taking prescribed Medications; and provision of supportive counseling.

186. **Tertiary Treatment:** Complementary medical, psychological, or rehabilitative procedures designed to eliminate, relieve or minimize mental or emotional disorders.

187. **Therapeutic Group Home:** A home providing planned Treatment to a child in a small residential Setting. Treatment includes theoretically based individual and group home Skills Development and Medication Management, Individual Therapy and Consultations as needed, to remediate significant impairments in the child's functioning that are the result of a principal mental or emotional disorder diagnosed on Axis I of the DSM multi-axial Diagnosis.

188. **Third Party Resources and Personal Injury Lien:** "Third Party Resources" mean any payments, benefits, or other resources available from a Third Party, including but not limited to:

a. Private health insurance or group health plan;

b. Employment-related health insurance;

c. Medical support from absent parents;

d. Workers' compensation;

e. Medicare;

f. Automobile liability insurance; and

g. Other federal programs such as Veteran's Administration, Armed Forces Retirees and Dependent Act (CHAMPVA), Armed Forces Active Duty and Dependents Military Medical Benefits Act (CHAMPUS), and Medicare Parts A and B, unless excluded by statute as for example:

(1) Services provided to OHP Members pursuant to 42 CFR 136.61 Indian Health Service (IHS) is the payor of last resort and is not considered a Third Party Resource; or

(2) Services provided to OHP Members at a tribal facility operated under a "638" agreement pursuant to the Memorandum of Agreement between IHS and CMS 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.

i. Another state's Title XIX, Title XXI, or state-funded Medical Assistance Program.

j. Personal estates.

189. **"365" Project:** One type of Extended Care Program which is a community-based alternative to Oregon State Hospital services developed on an individualized basis for persons with state hospitalization episodes of one year or longer. These are extended care projects that Provide intensive services and supports to enable approved adults to live in community rather than institutional Settings. Persons must be approved for placement in these projects by the AMH ECMU.

190. **Traditional Service:** A Medically Appropriate mental health service defined in the State of Oregon, OHP Service Categories for Per Capita Costs, October 2001 through September 2002. Traditional Services are those services that have historically been used to treat mental disorders and include services for which Medicaid FFS billing categories exist. For OHP Members under 21 years of age Traditional Services include the following: Interpreter Services; Assessment and Evaluation; Consultation; Clinical Services Coordination; Case Management; Medication Management; Individual Therapy, Family Therapy and Group Therapy; Multi-Family Treatment Group; Individual Skills Development and Group Skills Development; Intensive Treatment, Structure and Support; 24-hour Urgent and Emergency Response; and Acute Inpatient Hospital Psychiatric Care. For OHP Members 21 years of age and older Traditional Services include the following: Interpreter Services; Assessment and Evaluation; Consultation; Case Management; Medication Management; Individual Therapy, Family Therapy and Group Therapy; Daily Structure and Support; Individual and Group Skills Training; 24-hour Urgent and Emergency Response; Acute Inpatient Hospital Psychiatric Care; and Covered Services provided in a variety of residential Settings.

191. **Treatment:** A planned, Medically Appropriate, individualized program of interactive medical, psychological, or rehabilitative procedures, experiences, and/or activities designed to rehabilitate, relieve or minimize mental or emotional disorders identified through a mental health Assessment.

192. **Treatment Foster Care:** A program of rehabilitation as prescribed in the Treatment Plan and provided in the child's foster home. Skill development activities are delivered on an individualized basis and are designed to promote skill development in areas identified in the Treatment Plan. The service requires the use of Treatment Foster Care in coordination with other mental health interventions to reduce symptoms associated with the child's mental or emotional disorder and to provide a structured, therapeutic environment. The service is intended to reduce the need for future services, increase the child's potential to remain in the community, restore the child's best possible functional level, and to allow the child to be maintained in a least restrictive setting.

193. **Treatment Parameters:** The set of all variables that may affect the treatment of a client. Included in this set are providers, medical treatments, psychological treatments, and social interventions.

194. **Treatment Plan:** A written individualized comprehensive plan based on a completed mental health assessment documenting the OHP Member's treatment goals, Measurable Objectives, the array of services planned, and the criteria for goal achievement.

195. **Twenty-four (24) Hour Urgent and Emergency Services:** Services available 24 hours per day for persons experiencing an acute mental or emotional disturbance potentially endangering their health or safety or that of others, but not necessarily creating a sufficient cause for Civil Commitment as set forth in OAR 309-033-0200 through 309-033-0340.

196. **Urgent Care:** Care which is medically necessary within 48 hours to prevent a serious deterioration in an OHP Member's mental health.

197. **Urgent Situation:** A situation requiring attention within 48 hours to prevent a serious deterioration in an OHP Member's mental health.

198. **Usual and Customary Charges:** A required field in the encounter Minimum Data set which reflects the provider's charge per unit of service established in accordance with OAR 410-120-0000 or other applicable state and federal laws, rules and regulations, not in excess of the provider's usual and customary charge to the general public.

199. **Usual and Customary Treatment:** The application of treatment used to prevent the need for LTPC. Treatments include the following: (1) medical screens and Assessments used to rule out a medical condition or identify a medical condition that may be impacting a mental disorder; (2) Appropriate use of psychotropic Medications in therapeutic dosages and adjustments to such dosages to minimize side effects; (3) other cognitive and behavioral therapeutic interventions; and (4) review of options for discharge to nonhospital levels of care. For members who will be admitted to the OSH-GTS, Usual and Customary Treatment includes coordination of the stabilization of acute medical problems.

200. **Utilization:** The amount and/or pattern of Covered Services used by an OHP Member, measured, for example, in dollars, units of service, or staff time.

201. **Utilization Guidelines:** Guidelines for the amount of Covered Services expected to be used by an OHP Member with a specific mental disorder over time.

202. **Utilization Management:** The process used to regulate the provision of services in relation to the overall Capacity of the organization and the needs of Consumers.

203. **Valid Claim:** An invoice received by the Contractor for payment of Covered Services rendered to an OHP Member which can be processed without obtaining additional information from the provider of the service or from a third party; and has been received within the time limitations prescribed in Oregon Administrative Rule 410-141-0420; Billing and Payment under the Oregon Health Plan and is synonymous with the federal definition of a "clean claim" as defined in 42 CFR 447.45(b).

Exhibit B – Statement of Work

The Oregon Health Plan (OHP) has been restructured. The restructured OHP program in its entirety is referred to as "OHP2". OHP2 has three components, OHP Plus, OHP Standard and Family Health Insurance Assistance Program.

Exhibit B – Statement of Work – Part I - Benefits

1. Benefit Package

Contractor shall Provide OHP Plus Benefit Package and OHP Standard Benefit Package of Covered Services to OHP Members consistent with 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 Benefit Package of Covered Services. Covered Services shall be sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the Services are provided. Contractor shall ensure that the Services offered are in an amount, duration, and scope that is no less than that furnished to OHP Clients under FFS. Contractor may cover, for OHP Members, Services that are in addition to those covered under the State plan.

a. OHP Plus Benefit Package

A benefit package with a comprehensive range of Services available to OHP Members who are over the age of 65, the disabled, the TANF population, General Assistance recipients, pregnant women and children under the age of 19.

b. OHP Standard Benefit Package

A benefit package that provides basic health care Services for adults who are not otherwise eligible for Medicaid (Families, Adults/Couples). This benefit package has premiums requirements.

c. Flexible Services

When delivering a Flexible Service (as opposed to using a Flexible Service Approach) and the Provider rendering a Flexible Service is not licensed or certified by a state board or licensing agency, or employs personnel to Provide the Service who do not meet the definition for Qualified Mental Health Associate (QMHA) or Qualified Mental Health Professional (QMHP) as described in Exhibit A, Definitions, Provider must meet criteria described in Exhibit B, Part II, Section 4, Credentialing Process, Subsection a.(1)(b).

d. Provision of Covered Services

(1) Contractor shall provide reimbursement for Covered Services obtained outside its Service Area when such Covered Services are not available within its Service Area.

(2) Notwithstanding 410-141-0500, (1) (b), Contractor shall provide Covered Services as Medically Appropriate to those CAF children residing inside the Contractor's Service Area and those children whose placement by CAF for Behavioral Rehabilitative Services (BRS) is outside the Contractor's Service Area.

(3) Contractor shall Provide all Covered Services to OHP Members but may require, except in an emergency, that OHP Members obtain such Covered Services from Contractor or Providers affiliated with Contractor. Contractor shall adjudicate Valid Claims within 45 calendar days of receipt. Contractor shall ensure that neither DHS nor the OHP Member receiving Services are held liable for any costs or charges related to Covered Services rendered to an OHP Member whether in an emergency or otherwise.

(4) Contractor's obligation to pay for Emergency Services that are received from non-Participating Providers is limited to Covered Services that are needed immediately and the time required to reach Contractor or a Participating Provider (or alternatives authorized by Contractor) would have meant substantial risk to the OHP Member's health or safety or the health or safety of another.

(a) Covered Services following the provision of Emergency Services are considered to be Emergency Services as long as transfer of the OHP Member to Contractor or a Participating Provider or the designated alternative is precluded because of risk to the OHP Member's health or safety or that of another because transfer would be unreasonable, given the distance involved in the transfer and the nature of the mental health condition.

(b) Contractor is responsible for arranging for transportation and transfer of the OHP Member to Contractor's care when it can be done without harmful consequences.

(5) Contractor shall pay for Covered Services, subject to the protection of the prudent layperson requirements in Exhibit B-Part I, Section 1, Subsection d(4)(a) needed to assess an Emergency Situation. If Contractor has a reasonable basis to believe that Covered Services claimed to be Emergency Services were not in fact Emergency Services, Contractor may deny payment for such Services. Such Services shall not be considered Covered Services. In such circumstances, Contractor shall, within 45 calendar days of receipt of a claim for payment, notify:

(a) The Provider of such Services of the decision to deny payment, the basis for that decision, and the Provider's right to contest that decision.

(b) The OHP Member of the decision to deny payment as described in Exhibit N, MHO Grievance System.

(6) Contractor shall be responsible for Medicare deductibles, coinsurance and copayments for its OHP Members who are Medicare eligible receiving Covered Services from a Medicare Provider.

(7) Contractor may not prohibit or otherwise restrict a mental Health Care Professional (acting within the lawful scope of practice) from advising or advocating on behalf of an OHP Member for:

(a) the OHP Member's mental health care status, medical care or treatment options, including any alternative treatment that may be self-administered, regardless of whether Contractor provides benefits for the particular type of care or treatment;

(b) any information the OHP Member needs in order to decide among all the relevant treatment options;

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

(d) the OHP Member's rights to participate in decisions regarding his or her mental health care as cited in 42 CFR 438.102 (a)(1)(iv), including the right to refuse treatment, and to express preferences about future treatment decisions.

(8) Contractor shall Provide for a second opinion from a qualified mental Health Care Professional within the Provider Panel, or arrange for the ability of the OHP Member to obtain one outside the Provider Panel, at no cost to the OHP Member.

(9) As per 42 CFR 438.102, Contractor is not required to provide coverage or reimburse a counseling or referral Service if Contractor objects to the Service on moral or religious grounds. Contractor shall notify AMH if there are any Services not provided by the Contractor due to moral or religious reasons or if there is no limitation on Services. Contractor shall provide this notification with its application for a Medicaid contract at least 30 days before the start of the Agreement, or implementation of a newly adopted policy. If Contractor has not changed its policy regarding provision of Services since the beginning of the preceding contract year, it shall so notify AMH by submission of Schedule 5.1.

e. Mental Health Services Which are Not Covered Services

Contractor shall assist its OHP Members in gaining access to certain mental health Services that are not Covered Services and that are provided under separate contract with DHS. Services that are not Covered Services include, but are not limited to, the following:

(1) Medical Transportation;

(2) Medication;

(3) Therapeutic Foster Care reimbursed under HCPC Code S5145 for OHP Members under 21 years of age;

(4) Therapeutic Group Home reimbursed for OHP Members under 21 years of age;

(5) Behavioral Rehabilitative Services that are financed through Medicaid and regulated by DHS Services to Children and Families and OYA;

(6) Investigation of OHP Members for Civil Commitment;

(7) LTPC as defined in Exhibit B, Part II, Section 1, Subsection c (9), for OHP Members 21 years of age and older;

(8) PASRR for OHP Members seeking admission to a Nursing Home;

(9) LTPC for OHP Members age 17 and under;

(a) Secure Children's Inpatient program (SCIP)

(b) Secure Adolescent Inpatient Program (SAIP)

(c) Stabilization and Transition Services (STS)

(10) Extended care Services for OHP Members 18 years of age and older including Extended Care Management, Enhanced Care Services provided in DHS Seniors and People with Disabilities Program licensed facilities, "365" Projects, Psychiatric Vocational Projects, PASSAGES Projects, and other Services developed as less restrictive alternatives to LTPC at an Oregon State Hospital;

(11) Personal Care in Adult Foster Homes for OHP Members 21 years of age and older;

(12) Other Residential Services for OHP Members 21 years of age and older provided in Residential Care Facilities, Residential Treatment Facilities and Residential Treatment Homes;

(13) Services provided to persons while in the custody of a correctional facility or jail;

(14) Abuse investigations and protective Services as described in OAR 309-040-0200 through 309-040-0290, Abuse Reporting and Protective Services in Community Programs and Community Facilities, and ORS 430.735 through ORS 430.765, Abuse Reporting for the Mentally Ill; and

(15) Personal Care Services as described in OAR 411-034-0000 through 411-034-0090 and OAR 309-040-0300 through 309-040-0330.

f. Client Notices

Each time a Service or benefit will be terminated, suspended or reduced, or a request for Service authorization or request for claim payment is denied, Contractor shall issue a Notice of Action. Contractor is not obligated to issue a Notice of Action under one or more of the conditions described in Exhibit N, MHO Grievance System. Contractor shall make available in all clinics, Participating Provider offices, and other Service locations frequented by OHP Members, information concerning Client Notices, Grievances, Appeals, and Administrative Hearings.

g. Practice Guidelines

Contractor shall adopt practice guidelines that are based on valid and reliable clinical evidence or a consensus of mental health professionals. These practice guidelines must consider the needs of OHP Members, be adopted in consultation with Contractor's Participating Providers, and be reviewed and updated periodically as appropriate. Contractor shall disseminate the practice guidelines to all affected Providers and, upon request, to OHP Member or OHP Member Representative. Decisions for Utilization Management, coverage of Services, or other areas to which the guidelines apply, should be consistent with the adopted practice guidelines.

h. Utilization Management

(1) Contractor shall have written Utilization Management policies, procedures and criteria for Covered Services. These Utilization Management procedures shall be consistent with appropriate Utilization control requirements of 42 CFR Part 456.

(2) Contractor may adopt Treatment Parameters or Utilization Guidelines which result in limitations being placed on Covered Services; however, Contractor shall assure that Medically Appropriate level of Covered Services is provided based on the needs of the OHP Member regardless of limits specified in any such Treatment Parameters or

Utilization Guidelines. Contractor may not arbitrarily deny or reduce the amount, duration, or scope of a Covered Service solely because of the Diagnosis, type of illness, or condition, subject to the Prioritized List of Health Services.

(3) If Contractor adopts Treatment Parameters or Utilization Guidelines, Contractor shall provide copies of such existing Treatment Parameters and Utilization Guidelines to AMH as of the effective date of this Agreement, within 45 calendar days of change or adoption, and within 30 calendar days of AMH request.

(4) Contractor shall disseminate Treatment Parameters or Utilization Guidelines to all affected Providers and, upon request, to OHP Member or OHP Member Representative.

(5) If Contractor adopts Treatment Parameters or Utilization Guidelines, Contractor shall establish an Appeal process that allows for an independent clinical review of the decision by one or more QMHPs who were not involved in the original Utilization Management decision. Contractor may use its Appeal process for resolving Utilization Management Appeals.

(a) The Appeal process of Contractor shall afford those persons requesting Covered Services an expeditious method of reviewing Utilization Management decisions.

(b) Contractor shall have written policies and procedures for its Utilization Management Appeal process, notify organizations, agencies and Health Care Professionals requesting Covered Services of such process, and, upon request, provide a copy of written Utilization Management Appeal policies and procedures.

(c) Contractor shall maintain records of all Utilization Management appeals made and shall document all review decisions in writing. Records of Utilization Management Appeals and decisions shall be made available, within limits of laws or rules governing confidentiality, to the person appealing the original Utilization Management decision.

i. Authorization for Services

(1) Contractor and Subcontractor shall have procedures in place for the consistent application of review criteria for Service authorization decisions; service provision verification; consult with requesting Provider when appropriate; and that any decision to deny the amount, duration, or scope of a Service request be made by a Health Care Professional who has the appropriate clinical expertise in treating the OHP Member's mental health condition.

(2) Contractor shall have written policies and procedures for processing Service authorization requests received from an OHP Member or any Provider. This process shall include written notification to the OHP Member and the requesting Provider of any decision to deny a Service authorization request, or to authorize an amount, duration, or scope that is less than requested.

(3) For standard Service authorization requests, Contractor shall provide notice as expeditiously as the OHP Member's mental health condition requires, not to exceed fourteen (14) calendar days following receipt of the request for Service, with a possible

extension of 14 additional calendar days if the OHP Member or Provider requests extension, or if the Contractor justifies a need for additional information and how the extension is in the OHP Member's interest. If Contractor extends the time frame, Contractor shall give the OHP Member and Provider a written notice of the reason for the decision to extend the timeframe and inform the OHP Member of the right to file a Grievance if he or she disagrees with that decision. When a decision is not reached regarding a Service authorization request within the timeframes specified above, Contractor shall issue a Notice of Action to the Provider and OHP Member, or OHP Member Representative, consistent with Exhibit N, MHO Grievance System.

(4) If an OHP Member or Provider requests, or Contractor determines, that following the standard timeframes could seriously jeopardize the OHP Member's life or health or ability to attain, maintain, or regain maximum function, Contractor shall make an expedited Service authorization decision and provide Notice as expeditiously as the OHP Member's mental health condition requires and no later than 3 working days after receipt of the request for Service. Contractor may extend the 3 working days time period by up to 14 calendar days if the OHP Member requests an extension, or if Contractor justifies a need for additional information and how the extension is in the OHP Member's interest.

j. Contractor shall comply with ORS 127.703, Required Policies Regarding Mental Health Treatment Rights Information; Declaration for Mental Health Treatment.

2. Revision of Covered Services

Consistent with state law, Covered Services may be expanded, limited or otherwise changed by the HSC, by a vote of the people, or by the Legislative Assembly. Contractor shall Provide Covered Services consistent with the expansion or limitation, subject to Contractor's right to terminate this Agreement as provided for in Exhibit D, Section 10, Termination and Section 18, Amendments. DHS will promptly notify Contractor by certified mail of changes to Covered Services.

3. *(Reserved)*

4. Accessibility and Continuity of Care

a. Contractor shall meet, and require Providers to meet, OHP standards for timely access to care and Services, taking into account the urgency of need for Services. Contractor shall comply with OAR 410-141-0220, Oregon Health Plan Prepaid Health Plan Accessibility and OAR 410-141-0160, Oregon Health Plan Prepaid Health Plan Continuity of Care. Contractor shall ensure that Providers do not discriminate between OHP Members and non-OHP persons as it relates to benefits and services to which they are both entitled and shall ensure that Providers offer hours of operation to OHP Members that are no less than those offered to non-OHP Members.

b. In addition to access and Continuity of Care standards specified in the rules cited in Subsection a, of this section, Contractors shall establish standards for access to Covered Services and Continuity of Care which, at a minimum, include the following:

(1) For Urgent Services and Emergency Services, Contractor shall assure that OHP Members receive an initial face-to-face or telephone screening within fifteen minutes of contact to determine the nature and urgency of the situation.

(2) For Emergency Services, Contractor shall assure that OHP Members receive timely Covered Services within time frames identified by the urgent and emergency response screening or within 24 hours of contact, whichever is shorter.

(3) For Urgent Services, Contractor shall assure that OHP Members receive timely Covered Services within time frames identified by the urgent and emergency response screening or within 48 hours of request, whichever is shorter.

(4) For non-Urgent Services and non-Emergency Services, Contractor shall assure that OHP Members wait no more than two calendar weeks to be seen for an Intake Assessment following a request for Covered Services.

(5) For post-hospital services, Contractor shall assure that OHP Members receive a Covered Service within one calendar week following discharge from Acute Inpatient Psychiatric Hospital Care or that such OHP Members receive follow-up Covered Services within a Medically Appropriate period of time.

(6) For missed appointments, Contractor shall follow-up and reschedule appointments or Provide Outreach Services as Medically Appropriate or needed to prevent serious deterioration of the OHP Member's mental health condition.

(7) For routine travel time from the OHP Member residence to the Participating Provider, Contractor shall assure that OHP Members spend no more time traveling than the Community Standard.

(8) For OHP Members who are placed in substitute care by DHS, Contractor shall Provide a comprehensive mental health assessment consistent with access and Continuity of Care standards specified in Subsection a, of this section. Contractor shall provide this assessment no later than 60 days following the date of placement.

c. Contractor shall establish mechanisms to ensure that Providers comply with the timely access requirements, monitor regularly to determine compliance, and take corrective action if there is a failure to comply.

d. Contractor shall have a method of responding to telephone calls from non-English speaking OHP Members and shall make available to these OHP Members, interpreters capable of effectively receiving, interpreting and translating routine and clinical information.

e. Contractor shall have a method of responding to telephone calls from hearing impaired OHP Members and shall make available to these OHP Members, TDD Service and sign language or oral interpreters capable of effectively receiving, interpreting and translating routine and clinical information.

f. Contractor shall make Reasonable Accommodations to administrative practices and Service approaches for Service access and Continuity of Care for OHP Members with Disabling Conditions.

g. Contractor shall allow OHP Members to request an Assessment and Evaluation without obtaining a referral from another Provider.

h. Contractor shall Provide each OHP Member with an opportunity to select an appropriate Mental Health Practitioner and Service site.

i. Contractor shall Provide for the identified Covered Service needs of an OHP Member during transfer from one practitioner or hospital to another regardless of whether the practitioners or hospitals are Participating Providers. Contractor shall develop a written plan for Continuity of Care to avoid a worsening of the OHP Member's mental disorder when transitioning the OHP Member. Contractor shall document that such plan is acceptable to the OHP Member and/or OHP Member Representative or that the OHP Member and/or OHP Member Representative has been advised of the Grievance and Administrative Hearings processes.

j. Contractor shall not deny Covered Services to, or request Disenrollment of, an OHP Member based on disruptive or abusive behavior resulting from symptoms of a mental disorder or from another Disability. Contractor shall develop an Appropriate Treatment Plan with the OHP Member and the Family or advocate of the OHP Member to manage such behavior.

k. Contractor shall implement mechanisms to assess each OHP Member with Special Health Care needs in order to identify any ongoing special conditions that require a course of mental health treatment or care management. The assessment mechanisms must use appropriate Mental Health Practitioners.

(1) For OHP Members with Special Health Care Needs determined to need a course of treatment or regular care monitoring, the Treatment Plan must be developed by the Mental Health Practitioner with OHP Member participation and in consultation with any specialists caring for the OHP Member; approved by Contractor in a timely manner, if approval is required; and developed in accordance with any applicable DHS Quality Assessment and Performance Improvement and Utilization Review standards.

(2) Based on the assessment, Contractor shall assist OHP Member with Special Health Care Needs in gaining direct access when necessary and Medically Appropriate to mental health specialists for treatment of the OHP Member's condition and identified needs.

(3) Contractor shall implement procedures to share with OHP Member's primary health care provider and FCHP the results of its identification and assessment of any OHP Member with Special Health Care Needs so that those activities need not be duplicated. Such coordination and sharing of information shall be conducted within Federal and State laws, rules, and regulations governing confidentiality.

Exhibit B –Statement of Work – Part II – Providers and Delivery System

1. Delivery System Configuration

a. Needs Assessment

(1) Contractor shall, as per 42 CFR 438.206:

(a) Maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all Services covered under the Contract;

(b) In establishing and maintaining the network, the Contractor shall consider the following:

(i) The anticipated Medicaid Enrollment,

(ii) The expected Utilization of Services, taking into consideration the characteristics and healthcare needs of Medicaid Enrollees,

(iii) The numbers and types (in terms of training, experience, and specialization) of Providers required to furnish the contracted Medicaid Services,

(iv) The number of network Providers who are not accepting new Medicaid clients, and

(v) The geographic location of Providers and Medicaid Enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid Enrollees, and whether the location provides physical access for Medicaid Enrollees with Disabilities.

(2) In accordance with findings of the needs assessment, Contractor shall, on an ongoing basis, adjust its delivery system configuration and Capacity to make available timely and appropriate access to an adequate range and intensity of Covered Services options. These Covered Services options shall be provided in the least restrictive Treatment Settings.

(3) Contractor shall coordinate its needs assessment and Service delivery system planning effort with organized planning efforts carried out by the LMHA of its Service Area.

b. Components of the Delivery System

(1) Services Coordination

(a) Contractor shall have written policies and procedures for the provision of Services Coordination for those OHP Members with unique needs or requiring Services from more than one Local and/or Regional Allied Agency. Such policies and procedures shall be specific to these agencies.

(b) Contractor shall manage all Covered Services for its OHP Members with unique needs or requiring Services from more than one Local and/or Regional Allied Agency. Such policies and procedures shall be specific to these agencies.

(2) Preventive and Early Intervention Services

(a) Contractor shall establish and conduct preventive mental health and Psychoeducational Programs to decrease the incidence, prevalence, and residual effects of mental disorders in selected areas of the OHP Member population.

(i) Contractor shall have screening mechanisms to determine the presence and prevalence of mental disorders in its OHP Membership.

(ii) Contractor shall develop and adopt programs with the participation of Health Care Professionals, OHP Members, Family members and Local and/or Regional Allied Agencies.

(iii) Contractor shall have Services that are appropriate to the age, gender, socioeconomic status, ethnicity, clinical history, and risk characteristics of its OHP Membership.

(iv) Contractor shall have mechanisms to inform its OHP Members, Family members, and Health Care Professionals about its preventive and Psychoeducational Programs.

(v) Contractor shall have mechanisms to monitor the use of its preventive and Psychoeducational Programs and assess their impact on the OHP Membership.

(vi) Contractor shall take actions to improve the appropriate use of preventive and Psychoeducational Programs.

(b) Contractor shall regularly encourage OHP Members, Health Care Professionals, and Family members to use its preventive and Psychoeducational Programs and Services.

(3) Rehabilitative Treatment Services

(a) Contractor shall establish and make available Services for OHP Members who have non-urgent or non-emergency needs for Covered Services. These Services shall include Rehabilitative Covered Services.

(b) Contractor shall establish written policies and procedures that ensure Covered Services, which are Rehabilitative, are provided within Medically Appropriate time frames.

(4) 24 Hour Urgent and Emergency Response System

(a) Contractor shall Provide covered mental health Emergency Services that are needed immediately, or appear to be needed immediately by a prudent layperson, because of a sudden mental health condition. Contractor is responsible for coverage and payment for mental health Emergency Services and Post-Stabilization Services which are Medically Appropriate, until the emergency is stabilized, including those of non-participating Mental Health Practitioners or licensed facilities. Contractor may not deny payment for covered mental health Emergency Services or Post-Stabilization Services obtained under either of the following circumstances:

(i) an OHP Member had an Emergency Situation, including cases in which 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 in serious jeopardy, serious impairment or dysfunction of any bodily part or organ

(ii) when a representative of the Contractor, or its Providers, instructs the OHP Member to seek Emergency Services.

(b) Contractor may not limit what constitutes an Emergency Situation on the basis of lists of diagnoses or symptoms.

(c) Contractor may not refuse to cover Emergency Services based on Provider's failure to notify Contractor, of the OHP Member's screening and treatment, within 10 calendar days of the OHP Member's presentation for Emergency Services.

(d) An OHP Member who presents for Emergency Services may not be held liable for payment of subsequent Services needed to diagnose the specific condition or stabilize the OHP Member.

(e) The attending physician, or the Provider actually treating the OHP Member, is responsible for determining when the OHP Member is sufficiently stabilized for transfer or discharge, and that determination is binding on Contractor.

(f) Contractor is financially responsible for Post-Stabilization Services under the following circumstances:

(i) Post-Stabilization Services have been authorized by Contractor, or Contractor's delegated entity;

(ii) Post-Stabilization Services were provided to maintain the OHP Member's stabilized condition within 1 hour of a request to the Contractor, or Contractor's delegated entity for pre-approval of further Post-Stabilization Services;

(iii) Post-Stabilization Services were provided to maintain, improve, or resolve the OHP Member's stabilized condition if Provider does not receive a response to a request for pre-approval within 1 hour; the Contractor, or Contractor's delegated entity cannot be contacted; or an agreement cannot be reached between Contractor's delegated entity and Provider and Contractor is not available for consultation. In this situation, the treating Provider may continue Services to the OHP Member until Contractor can be reached.

(g) Contractor's financial responsibility ends for Post-Stabilization Services that have not been pre-approved when:

(i) Contractor's Participating Provider with privileges at the treating hospital assumes responsibility for the OHP Member's care;

(ii) Contractor's Participating Provider assumes responsibility for OHP Member's care through transfer;

(iii) Contractor's delegated entity and Provider reach an agreement concerning the OHP Member's care; or

(iv) The OHP Member is discharged.

(h) Contractor shall establish, consistent with OAR 410-141-0140, Oregon Health Plan Prepaid Health Plan Emergency and Urgent Care Medical Services, an Urgent and Emergency Response System that operates 24 hours per day, 7 days per week.

(i) Contractor shall have, and adhere to, written policies and procedures for an Emergency Response System that provides an immediate, initial and/or limited duration response consisting of: a telephone or face to face screening to determine the nature of the situation and the person's immediate need for Covered Services; capacity to conduct the elements of a mental health Assessment that are needed to determine the interventions necessary to begin stabilizing the crisis situation; development of a written initial Services plan at the conclusion of the mental health Assessment; provision of Covered Services and/or Outreach needed to address the Urgent or Emergency Situation; and linkage with the public sector crisis services, such as precommitment.

(5) Involuntary Psychiatric Care

(a) Contractor shall make a reasonable effort to Provide Covered Services on a voluntary basis and consistent with current Declaration for Mental Health Treatment in lieu of involuntary treatment.

(b) Contractor shall have written policies and procedures describing the Appropriate use of Emergency Psychiatric Holds and alternatives to Involuntary Psychiatric Care when a less restrictive voluntary Service will

not meet the Medically Appropriate needs of the OHP Member and the behavior of the OHP Member meets legal standards for the use of an Emergency Psychiatric Hold.

(c) Contractor shall only use psychiatric inpatient facilities and non-inpatient facilities certified by DHS under OAR 309-033-0200 through 309-033-0340, Standards for the Approval of Facilities that Provide Care, Custody and Treatment to Committed Persons or to Persons in Custody or on Diversion, to Provide Emergency Psychiatric Holds.

(d) Contractor shall comply with ORS Chapter 426, OAR 309-033-0200 through 309-033-0340, and OAR 309-033-0400 through 309-033-0440 for involuntary Civil Commitment of those OHP Members who are civilly committed under ORS 426.130.

(e) Contractor shall administer Medication to OHP Members held or civilly committed under ORS Chapter 426, regardless of Setting, only as permitted by applicable statute and administrative rule. Contractor shall not transfer civilly committed OHP Members to a State Hospital for the sole purpose of obtaining authorization to administer Medication on an involuntary basis.

(6) Acute Inpatient Hospital Psychiatric Care

(a) Contractor shall maintain agreements with local and regional hospitals for the provision of emergency and non-emergency hospitalization for OHP Members with mental disorders that require Acute Inpatient Hospital Psychiatric Care. Hospitals selected must comply with standards as described in Exhibit B, Part II, Section 4, Credentialing Process, Subsection a.(2) and (3).

(b) Contractor shall cover the cost of Acute Inpatient Hospital Psychiatric Care for OHP Members who do not meet the criteria for LTPC.

(c) Contractor may request of AMH ECMU the transfer of an OHP Member from an Acute Inpatient Hospital Psychiatric Care Setting to a highly secure psychiatric Setting when Contractor believes that the extremely assaultive behavior of the OHP Member warrants such a Setting. If the OHP Member does not consent to such a transfer, Contractor may, subject to applicable law, initiate an Emergency Psychiatric Hold and a precommitment investigation. The care rendered to an OHP Member transferred to a highly secure psychiatric Setting at Contractor's request is a Covered Service and the cost thereof shall be borne by Contractor unless and until the OHP Member is determined Appropriate for LTPC in accordance with the process described in this Agreement. If the OHP Member is admitted to a State Hospital, Contractor shall pay the usual and customary rates for this level of Service until such time as the OHP Member is discharged or determined Appropriate for LTPC.

(d) Contractor shall coordinate admissions to and discharges from Acute Inpatient Hospital Psychiatric Care for OHP Members in the care and custody of DHS Children, Adults, and Family Services or OYA with such OHP Member's DHS Services to Children and Families or OYA case manager. For an OHP Member placed by DHS Children, Adults, and Family Services through a Voluntary Child Placement Agreement (SCF form 499), coordination shall also occur with such OHP Member's parent or legal guardian.

(7) Contractor shall take into consideration the Service needs of OHP Members with Special Health Care Needs when establishing its Provider network.

(8) ISA for Children and Adolescents

(a) The ISA is a range of service components that are coordinated, comprehensive, Culturally Competent, and include intensive and individualized home and community-based services for children and adolescents, through and including age 17. These services target the population with severe mental or emotional disorders whose needs have not been adequately addressed in traditional Settings. The ISA integrates inpatient, psychiatric residential and Psychiatric Day Treatment, and community-based care provided in a way to ensure that children and adolescents are served in the most natural environment possible and that the use of institutional care is minimized. The intensity, frequency, and blend of these services are based on the mental health needs of the child. Contractor shall ensure that the ISA will be recovery focused, family driven, and time limited based on Medically Appropriate criteria. In communities that lack AMH certified Psychiatric Day Treatment programs for children and adolescents, Contractor may develop individualized alternatives.

(b) Contractor shall develop and implement a system for the ISA that provides cost effective, comprehensive and individualized care to children and their families.

(i) Contractor shall have a system that promotes collaboration, within laws governing confidentiality, between mental health, child welfare, juvenile justice, education, families, and other community partners in the treatment of children with serious emotional, mental health and behavioral challenges.

(ii) Contractor shall assure access to referral and screening at multiple entry points.

(iii) Contractors shall Provide Services that are family-driven, strengths-based, are culturally sensitive, and that enhance and promote quality, community-based Service delivery.

(c) Contractor shall have policies and procedures in place to assess all OHP Members who are children and adolescents suspected of having significant mental or emotional disorders.

(i) The Child and Adolescent Service Intensity Instrument (CASII) will be used as the statewide tool to assist in the determination for ISA services for children age 6 and older.

(ii) Contractor will prioritize children with the most serious mental health needs for the ISA who have a mental health Diagnosis that is on or above the funded line of the OHP Prioritized List of Health Services. This mental health Diagnosis must be the focus of the ISA and the Treatment Plan. In addition to meeting the CASII criteria for level 4, 5, or 6, Contractor shall take into consideration factors including, but not limited to:

(A) exceeding usual and customary services in an outpatient Setting;

(B) multiple agency involvement;

(C) multiple out-of-home placements;

(D) significant risk of out-of-home placement;

(E) frequent or imminent admission to acute inpatient psychiatric hospitalizations or other intensive treatment services;

(F) caregiver stress;

(G) school disruption due to mental health symptomatology; or

(H) elevating or significant risk of harm to self or others.

(iii) The ISA determination process shall be clearly communicated to Family members, guardians, and community partners, and shall encourage ISA referrals from multiple sources, including families, Allied Agencies, schools, juvenile justice, the faith community and health care providers.

(iv) Contractor shall make decisions regarding ISA determinations and referrals to Services within three (3) working days consistent with Contractor's policies and procedures required in Exhibit B, Part II, Section 1, Subsection b, Paragraph (8)

(v) OHP Members meeting the determination process outlined in Exhibit B, Part II, Section 1, Subsection b, Paragraph (8) (c) (ii) for intensive treatment services shall have access to care coordination, shall have available a child and family team planning process and access to the ISA.

(vi) Contractor shall continue to Provide Services consistent with access standards identified in Exhibit B, Part I, Section 4, Subsection a and Subsection 2, Paragraph (1) through (4) for the time period between level of need determination and implementation of the service plan.

(vii) Contractor shall submit written policies and procedures for CASII administration and ISA determination processes to AMH within 30 calendar days of the effective date of this Agreement. AMH will review the policies and procedures and notify Contractor of its determination within 30 days of receipt.

(viii) Contractor shall assure that admissions to psychiatric residential treatment services are consistent with the admission and certification requirements of 42 CFR 456.481.

(d) Contractor shall assure that Service Coordination will be provided by a person or persons who have a strong child and adolescent mental health background, extensive knowledge of the children's system of care, and experience working with families.

(i) Community Care Coordination shall Provide guidance and Case Management services in the planning, facilitating, and coordination of the child's Service Coordination plan.

(ii) A child and family team shall assist in the development of the Service Coordination plan. The team may include the child, if appropriate, Family members, child serving agencies involved with the child, school, and other community supports identified by the Family.

(iii) The child and family team will support and help facilitate access to a combination of Services, informal and formal supports, and other community resources.

(e) Contractor shall develop and implement a Community Care Coordination Committee that is a community level planning and decision making body to provide practice-level consultation, identify needed community services and supports, and provide a forum for problem solving to families, ISA providers, child serving agencies, and child and family teams. The Community Care Coordination Committee shall have representation of the local system of care that includes Consumer and Family members, child serving providers, child and family advocates, and other local Stakeholders representative of the local system of care.

(f) The ISA rate methodology is based on a model which considers:

(i) the historical Utilization of intensive treatment services, and

(ii) the percentage of children under age 17 who are enrolled with Contractor.

(g) Contractor shall develop and implement a regional or local children's mental health system advisory council. The advisory council will advise Contractor and provide oversight of the local or regional mental health policies and programs for the ISA, as well as ensure continuous QI.

(i) The advisory council shall have representation from child welfare, juvenile justice, education, developmental disabilities, physical health plan, ISA providers, and other local or regional community partners representative of the local system of care, culturally diverse populations of mental health Consumers and their Family members.

(ii) Representation by Consumers, Family members and child and family advocates on this advisory council shall be a minimum of 51% of total membership, with half of the representation consisting of OHP Members who are adolescent consumers and family members of OHP Members who are child and adolescent consumers.

(h) Contractor shall work closely with AMH to ensure continuous Enrollment for children and adolescents determined as meeting the criteria for the ISA who are placed in treatment facilities outside Contractor's Service Area, as defined in Part IV of this Agreement. Contractor shall notify AMH when an Enrollee is admitted to an out of area program, as well as when the Enrollee is scheduled for discharge from the program. AMH will work with DHS staff to make the system adjustments that are necessary to accomplish continuous Enrollment with Contractor. Eligibility determinations will not be affected and will continue to be subject to the DHS criteria for participation in the OHP.

(i) Contractor shall develop a process to assure that funding intended and allocated for children's mental health is used for that purpose.

(i) Performance targets for the percentage of expenditures on services to children and adolescents shall be equal to the percentage of revenues based on child and adolescent OHP Members.

(ii) OHP Members meeting criteria for the ISA, as described in Exhibit B, Part II, Section 1, Subsection b, Paragraph (8) (c), shall be served by a provider certified to Provide intensive community based treatment services under OAR 309-032-1240 to 309-032-1305.

(iii) AMH will provide Contractor with performance targets that identify funding amounts that are to be spent with organizations certified to Provide intensive treatment services under Oregon Administrative Rule 309-032-1100 through 309-032-1230. AMH will take into account Contractor's formal efforts to contract with ITS providers. Funds may be used to purchase non-traditional as well as traditional mental health services.

(j) Contractor shall have contractual relationships or memorandums of understanding with Providers certified to Provide intensive treatment services that demonstrate adequate and sufficient Capacity to Provide the ISA.

(k) Contractor shall ensure that all programs involved in the ISA meet the Credentialing Standards as outlined in Exhibit B, Part II, Section 4, of this Agreement and are licensed and certified by DHS under the Applicable Oregon Administrative Rules for the Program.

(l) Contractor shall have policies and procedures in place to assure timely reimbursement to Providers participating in the ISA.

(i) Whenever Contractor reimburses a non-contract provider of Psychiatric Day Treatment Services or Psychiatric Residential Treatment Services for services identical to those purchased by AMH through direct contracts, the reimbursement shall be no less than the amount paid by AMH for the same services.

(m) Contractor shall have written policies and procedures describing the admission and discharge criteria for a child or adolescent requiring the ISA level of care. Process shall include the active participation of the Family, Allied Agencies, and other persons involved in the child's care.

(n) Contractor shall be required to submit additional reports and information as identified by AMH for the purposes of QA/PI activities of the ISA. Contractor shall work with AMH to identify specific outcomes and performance measures that will be tracked and reported on a quarterly basis.

(i) AMH will conduct an annual survey of Family members/caregivers of child and adolescent OHP Members receiving Covered Services and will provide aggregate results and raw data received from Contractor's members to the Contractor.

Contractor shall be required to submit additional reports and information derived from this aggregate data as identified by AMH for the purposes of QA/PI activities of the ISA. Contractor shall work with AMH to identify specific outcomes and performance measures that will be tracked and reported on a quarterly basis.

(ii) Contractor shall collect and analyze CASII data for QA/PI activities. Contractor shall submit to AMH, within 60 days of the end of each calendar quarter, a report consistent with Schedule 4, Level of Need Determination Data.

(iii) Contractor shall collaborate and assist AMH in the collection and reporting of data for use in an ISA Progress Review, as indicators of outcome and performance measure. Data shall include the following domains:

(A) School;

(B) Home, life, and Family;

(C) Client functioning; and

(D) Critical incidents.

This data reporting shall commence as soon as feasible, The Parties intend that the negotiated specifications of a standardized format be incorporated by amendment to this Agreement.

(o) In addition to the Utilization Management requirements stated in Exhibit B, Part I, Section 1, Subsection h, Contractor shall assure that admissions to psychiatric residential treatment programs are consistent with the admission and certification requirements of 42 CFR 456.481 and 441.150 through 441.156.

c. Integration and Coordination

Contractor shall ensure that in the process of coordinating care, the OHP Member's privacy is protected consistent with the confidentiality requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable, and consistent with other State law or Federal regulations governing privacy and confidentiality of mental health records.

(1) Mental Health Services Which Are Not Covered Services

Contractor shall coordinate Services for each OHP Member who requires Services from agencies providing mental health Services that are not Covered Services. These Services include, but are not limited to, those listed in Exhibit B, Part I, Section 1, Subsection e, Mental Health Services Which Are Not Covered Services.

(a) Contractor shall assist OHP Members who are children and adolescents age 17 and under in gaining access to Psychiatric Long Term Care when this level of care is Medically Appropriate.

(i) Contractor shall work closely with AMH staff to ensure continuous Enrollment for OHP Members entering into LTPC outside of Contractor's Service Area as defined in Part IV of this Agreement.

(ii) To ensure that treatment is being provided in the least restrictive and most appropriate Setting, Contractor shall, at minimum, consult and communicate with LTPC programs for admission and discharge planning, and collaborate with the LTPC program regarding ongoing treatment decisions.

(iii) Contractor shall coordinate, consult, and communicate, within the laws governing confidentiality, with community providers and other Allied Agencies, schools, Family members or guardians regarding treatment for children and adolescents in LTPC.

(2) Local Mental Health Authority (LMHA)/Community Mental Health Program (CMHP)

Contractor shall establish working relationships with the LMHA and CMHP operating in the Service Area for the purposes of maintaining a comprehensive and coordinated crisis response and mental health Service delivery system for OHP Member access to mental health Services, including Civil Commitment and protective Services/abuse investigations processes.

(3) Community Emergency Service Agencies

Contractor shall coordinate, consult, communicate with, and provide technical assistance to Community Emergency Service Agencies to promote appropriate responses to, and Appropriate Services for, OHP Members experiencing a mental health crisis.

(4) Local and/or Regional Allied Agencies

Contractor shall have a mechanism for multi-disciplinary team Service planning and Services Coordination for OHP Members requiring Services from more than one publicly funded agency or Service Provider. This mechanism shall help avoid Service duplication and promote access to a range and intensity of Service options that Provide individualized, Medically Appropriate care in the least restrictive Treatment Setting (clinic, home, school, community based care Settings licensed by local or Allied Agencies).

(a) Contractor shall work with DHS local and/or regional agencies to develop specific methods for meeting federal requirements for a mental health assessment for children and adolescents within 60 days of placement in substitute care.

(5) Physical Health Care Providers

Contractor shall coordinate with physical health care Providers and FCHPs to ensure that each OHP Member has an ongoing source of primary care appropriate to their needs.

(a) Consult and communicate with the OHP Member's physical health care Provider as Medically Appropriate and within laws governing confidentiality as specified in OAR 410-141-0180, Oregon Health Plan Prepaid Health Plan Recordkeeping.

(b) Consult with, and provide technical assistance to, physical health care Providers in the Service Area to help in the early identification of mental disorders so that intervention and Prevention strategies can begin as soon as possible.

(c) Develop and implement methods of coordinating with FCHPs for the appropriate coordination of Services delivered to OHP Members, particularly OHP Members with exceptional Service needs. Such coordination shall be conducted within laws governing confidentiality.

(6) Chemical Dependency Providers

Contractor shall coordinate with Chemical Dependency Providers as Medically Appropriate and within laws governing confidentiality and shall provide technical assistance for the identification and referral of OHP

Members with dual diagnoses. Contractor shall work with FCHPs and Chemical Dependency Providers certified by DHS to develop the Capacity to Provide Appropriate Services to dually diagnosed OHP Members so the needs of such persons can be better met.

(7) Medicare Payers and Providers

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

(8) OHP Members in Extended Care Settings

Contractor shall coordinate with the AMH ECMU and extended care Service Providers to integrate Services for OHP Members in Extended Care Programs. ECMU shall determine, after collaborating with Contractor and the Extended Care Program, when an OHP Member is ready for discharge from the Extended Care Program.

(9) Long Term Psychiatric Care (LTPC)

(a) If Contractor believes an OHP Member is Appropriate for LTPC, Contractor shall request a LTPC determination from the applicable DHS program. DHS staff will render a determination within three working days of receiving a completed request if the OHP Member is 18 or more years of age or within seven working days of receiving a completed request if the OHP Member is age 17 and under.

(i) For OHP Members age 18 to age 64 with no significant nursing care needs due to an Axis III disorder of an enduring nature, the AMH ECMU as described in Schedule 2.1, Procedure for LTPC Determinations for OHP Members Age 18-64;

(ii) For OHP Members age 17 and under, the AMH Child and Adolescent Community Mental Health Specialist as described in Schedule 2.2, Procedure for LTPC Determinations for OHP Members age 17 and under; and

(iii) For OHP Members age 65 and over or age 18 to age 64 with significant nursing care needs due to an Axis III disorder of an enduring nature, the OSH-GTS, Outreach and Consultation Service (OCS) Team as described in Schedule 2.3, Procedure for Long Term Psychiatric Care Determinations for Persons Requiring Geropsychiatric Treatment.

(b) An OHP Member is Appropriate for LTPC when the OHP Member needs either Intensive Psychiatric Rehabilitation or other Tertiary Treatment in a State Hospital or Extended Care Program, or Extended and Specialized Medication Adjustment in a secure or otherwise highly supervised environment; and the OHP Member has received all Usual and Customary Treatment, including, if Medically Appropriate, establishment of a Medication Management Program and use of a Medication Override Procedure.

(c) DHS will cover, the cost of LTPC of OHP Members determined Appropriate for such care beginning on the effective date specified below in this Exhibit B, Part II, Section 1, Subsection c, Paragraph (9) (c) and ending on the date the OHP Member is discharged from such setting

If an OHP Member is ultimately determined Appropriate for LTPC, the effective date of such determination shall be either:

(i) The date ECMU receives a completed Request for LTPC Determination for Persons Age 18 to 64 form, or

(ii) No more than seven (7) working days following the date the AMH Child and Adolescent Mental Health Specialist receives a completed request for LTPC Determination for Persons Age 17 and under form; or

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

(iv) In cases where AMH and Contractor mutually agree on a date other than these dates, the date mutually agreed upon.

(v) In cases where the Clinical Reviewer determines a date other than a date described above in this Exhibit B, Part II, Section 1, Subsection c, Paragraph (9) (c) (i)through (9) (c) (iii), the date determined by the Clinical Reviewer.

In the event there is a disagreement between Contractor and AMH about whether an OHP Member is Appropriate for LTPC, Contractor may request, within three (3) working days of receiving notice of the LTPC determination, review by an independent Clinical Reviewer. The determination of the Clinical Reviewer shall be deemed the determination of AMH for purposes of this Agreement. If the Clinical Reviewer ultimately determines that the OHP Member is Appropriate for

LTPC, the effective date of such determination shall be the date specified above in this Exhibit B, Part II, Section 1, Subsection c, Paragraph (9) (c). The cost of the clinical review shall be divided equally between Contractor and AMH.

(d) Contractor shall:

(i) For OHP Members age 18 to 64, work with the AMH ECMU, or OCS Team in managing admissions to and discharges from LTPC for OHP Members who require such care at OSH or Eastern Oregon Psychiatric Center.

(ii) For OHP Members, age 17 and under, work with the AMH Child and Adolescent Mental Health Specialist in managing admissions and discharges to LTPC (SCIP, SAIP, STS programs).

(iii) For the OHP Member and, the parent or guardian of the OHP Member, work to assure timely discharge from LTPC to an Appropriate community placement.

(iv) For the OSH-GTS Interdisciplinary Treatment Team assigned to the OHP Member, work to manage discharges from Long Term Geropsychiatric Care.

(e) Contractor shall authorize and reimburse case management services that are sufficient in amount, duration or scope to reasonably be expected to achieve the purpose for which the services are provided to OHP Members receiving care through community-based Long Term Psychiatric Care, as authorized by the AMH Extended Care Management Unit

(f) Contractor shall assure that any involuntary treatment provided under this Agreement is provided in accordance with administrative rule and statute, and shall coordinate with the CMHP Director in assuring that all statutory requirements are met. Contractor shall also work with the CMHP Director in assigning a civilly committed OHP Member to any placement and participate in circuit court hearings related to planned placements, if applicable.

(10) Consumer Involvement and Advocacy

(a) Contractor shall involve Consumers, families, Consumer advocates, and advocacy groups in planning, developing, implementing, operating and evaluating Services.

(b) Contractors' advisory bodies, such as QI committees, policy-making bodies or decision-making boards, shall have representation from culturally diverse populations of mental health Consumers and their Family members. Representation on these advisory bodies shall be a minimum of 25% of total membership and shall consist of representatives which include the

following constituent groups: adolescent Consumers, adult Consumers, older adult Consumers, Family members of child and adolescent Consumers and Family members of adult and older adult Consumers.

(c) Contractor shall inform OHP Members, at least once per year, of the OHP Member's abilities to participate in activities of Contractor.

2. Delivery System Capacity

a. Contractor shall have written policies and procedures for selection and retention of providers. Contractor shall maintain and monitor a Provider Panel that is supported with written agreements, and that has sufficient Capacity and expertise to Provide adequate, timely and Medically Appropriate access to Covered Services to OHP Members across the age span from child to older adult. In establishing and maintaining the Provider Panel, Contractor shall consider the following:

(1) An appropriate range of preventive and specialty services for the population enrolled or expected to be enrolled in Contractor's Service Area;

(2) The expected Utilization of Services, taking into consideration the characteristics and mental health care needs of OHP Members;

(3) The number and types (in terms of training, experience, and specialization) of Providers required to Provide Services under this Agreement;

(4) The number of Providers who are not accepting new OHP Members;

(5) The geographic location of Providers and OHP Members, considering distance, travel time, the means of transportation ordinarily used by OHP Members, and whether the location provides physical access for OHP Members with disabilities;

(6) Contractor shall allow each OHP Member to choose a Provider within Contractor's Provider Panel to extent possible and appropriate.

(7) Contractor shall provide OHP Members with access, as Medically Appropriate, to psychiatrists, other licensed medical professionals, or mental health professionals.

b. Contractor shall identify training needs of its Provider Panel and address such needs to improve the ability of the Provider Panel to deliver Covered Services to OHP Members.

c. If Contractor is unable to Provide necessary Covered Services which are Medically Appropriate to a particular OHP Member within its Provider Panel, Contractor shall adequately and timely cover these services out of network for the OHP Member, for as long as Contractor is unable to Provide them. Out of network providers must coordinate with Contractor with respect to payment. Contractor shall ensure that cost to OHP Member is no greater than it would be if the Services were provided within the Provider Panel.

d. Contractor shall participate in AMH efforts to promote the delivery of Services in a Culturally Competent manner to OHP Members, including those with limited English proficiency and diverse cultural and ethnic backgrounds.

3. Quality Assessment/Performance Improvement (QA/PI) Requirements

a. QA/PI Program

(1) The QA/PI Program shall be in accordance with 42 CFR 438.240, QA/PI. Contractor and its Subcontractors shall have an ongoing QA/PI program for the services it furnishes to its enrollees. The basic elements of the Contractor's QA/PI program must comply with the following requirements:

(a) Implementation of a minimum of two (2) performance improvement projects (PIP) annually that are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have favorable effect on health outcomes. Contractor shall perform a mental health/physical health collaborative PIP with a Fully Capitated Health Plan/Physician's Care Organization (PCO) also serving Oregon Health Plan Members in Contractor's Service Area. As an alternative to a collaborative PIP, Contractor may propose another PIP to AMH which must be reviewed by and have prior approval by AMH. The PIPs must involve:

(i) Measurement of performance using objective quality indicators.

(ii) Implementation of system interventions to achieve improvement in quality.

(iii) Evaluation of the effectiveness of the interventions.

(iv) Planning and initiation of activities for increasing or sustaining improvement.

(v) Completion in a reasonable time period as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on Quality of Care every year.

(b) Submission of performance measurement data annually that includes:

(i) Standard measures required by the State including those that incorporate standards established by the State;

(ii) Submission to the State, data specified by the State, that enables the State to measure the MHO's performance; or

(iii) A combination of Exhibit B, Part II, Section 3, Subsections a. and b., as approved by the State.

(c) Have in effect mechanisms to detect both underutilization and over utilization of services.

(d) Have in effect mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs.

(e) Any delegated QA/PI activity shall state the extent of the delegation and how these activities are monitored and integrated in the overall QA/PI program.

(2) Contractor's QA/PI Committee shall demonstrate evidence of stakeholder participation in the QA/PI program including a formal and ongoing process for gathering and considering information from Stakeholders including, but not limited to: OHP Members, consumers, consumer advocates, Families, parent advocates, family members of older adults, Local and/or Regional Allied Agencies, child psychiatrists, geropsychiatrists, child advocates, and Health Care Professionals.

(3) Contractor shall communicate to Providers the overall QA/PI Program findings, including recommendations and opportunities for improvement.

b. QA/PI Work Plan

Contractor shall develop and submit for approval to the AMH a written QA/PI Work Plan within 45 days of the effective date of this Agreement. AMH shall review the QA/PI Work Plan and shall notify Contractor of its determination of approval within 30 days of receipt.

(1) Contractor shall introduce interventions and monitor progress in the domains of access to services; quality of services; integration and coordination of services; prevention, education and outreach; and clinical outcomes.

c. QA/PI Program Review

Contractor shall have in effect a process for the annual evaluation of the impact and effectiveness of its QA/PI program. The review shall include performance on standard measures as required by the State and the results of each performance improvement project. The review shall include the analysis and integration of Grievance information into the QA/PI program. Contractor shall submit the evaluation 45 days after the termination of this Agreement.

d. Member of AMH QA/PI Committee

Contractor shall participate as a member of the AMH QA/PI Committee if such participation is requested by AMH.

e. External Quality Review

In conformance with 42 CFR 438 Subpart E, Contractor, or its Subcontractors and Providers shall cooperate with DHS by providing access to records and facilities for the purpose of an annual external, independent professional review of the quality outcomes and timeliness of, and access to, Services provided under this Agreement. If the External Quality Review Organization (EQRO) identifies an adverse clinical situation in which follow-up is needed to determine whether Appropriate care was provided, the EQRO shall report the findings to AMH and Contractor. Contractor shall assign a staff person(s) to

follow-up with the Subcontractor or Provider, inform Contractor's QI Committee of the finding, and involve the QI Committee in the development of the resolution. Contractor shall report the resolution to AMH and the EQRO. If determined by AMH, at the recommendation of the EQRO, Contractor shall develop and comply with a corrective action plan as reviewed and approved by AMH.

4. Credentialing Process

a. Contractor shall have policies and procedures for Credentialing and recredentialing Providers, which includes collecting evidence of credentials and screening the credentials of Providers, programs and facilities used to deliver Covered Services. These policies and procedures shall be consistent with OAR 410-141-0120, Oregon Health Plan Prepaid Health Plan Provision of Health Care Services and shall include verifying possession of valid licenses or certificates if any are required under any federal, state, or local law, rule, or regulation to deliver Covered Services in the State of Oregon. These policies and procedures shall also include collecting proof of liability insurance and evidence of hospital privileges of physicians rendering Services in an Acute Inpatient Hospital Psychiatric Care Setting.

(1) If Participating Providers are not required to be licensed or certified by a State of Oregon board or licensing agency, then:

(a) Participating Providers must meet the definitions for QMHA or QMHP as described in Exhibit A, Definitions and Provide Services under the supervision of a LMP as defined in Exhibit A, Definitions; or

(b) For Participating Providers not meeting either the QMHP or QMHA definition, Contractor shall document and certify that the person's education, experience, competence, and supervision are adequate to permit the person to perform his or her specific assigned duties.

(2) All programs operated directly or by subcontract must be accredited by nationally recognized organizations (e.g., Council on Accredited Rehabilitation Facilities (CARF), JCAHO and/or are certified under OAR 309-012-0130 et. seq. or licensed under ORS Chapter 443 by the State of Oregon to deliver specified Services (e.g. OAR 309-032-0525 through 309-032-0605, Standards for Adult Mental Health Services; OAR 309-032-0950 through 309-032-1080, Standards for Community Treatment Services for Children; OAR 309-032-1100 through 309-032-1230, Intensive Treatment Services; and OAR 309-032-1240 through 309-032-1305, Intensive Community Based Treatment and Support Services; and OAR 309-039-0500 through 309-039-0580, Standards for Approval of Providers of Non-Inpatient Mental Health Treatment Services).

(3) Facilities used to deliver services specified in OAR 309-032-0850 through 309-032-0890, Standards for Regional Acute Care Psychiatric Services for Adults, OAR 309-033-0700 through 309-033-0740, Standards for the Approval of Community Hospital and Non-hospital Facilities to Provide Seclusion and Restraint to Committed Persons in Custody or on Diversion and OAR 309-032-1100 through 309-032-1230 must be certified or licensed by the State of Oregon and be safe and adequately equipped and adequately staffed for Covered Services provided.

(4) Contractor shall periodically check that Participating Providers, programs and facilities are credentialed as specified above.

b. Contractor Credentialing records shall document academic degrees, licenses, certifications, and/or qualifications of Participating Providers, programs and facilities. If the Covered Service is Acute Inpatient Hospital Psychiatric Care, Contractor need not maintain Credentialing records of hospital staff but shall maintain records documenting that the facility is appropriately licensed.

c. Contractor's Subcontractors and Participating Providers shall work within the scope of registration or licensure and qualifications specified in Exhibit B, Part II, Subsection 4, Credentialing Process, Items a(1) through a(c).

d. Contractor shall have a staff development program for improving knowledge, skills and competency of staff in Psychiatric Rehabilitation principles and delivery of Covered Services.

e. Contractor shall provide written notice of termination of a Participating Provider, within 15 days after receipt or issuance of the termination notice, AMH and each OHP Members who received care, or was seen on a regular basis, by the terminated Provider.

f. If Contractor must terminate a Provider or Provider group due to problems that could compromise the OHP Member's care, less than the required notice to AMH and the OHP Member may be provided.

g. Facilities used for Acute Inpatient Hospital Psychiatric Care shall have separate units for the Treatment of children and adults (OHP Members ages 18 and older); or Contractor may propose, for AMH approval, an alternative to separate units which provides for the safety and protection of all Acute Inpatient Hospital Psychiatric Care patients.

h. Contractor's provider selection policies and procedures shall not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that 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 OHP Members or from establishing any measure designed to maintain quality and control costs consistent with Contractor's responsibilities under this Agreement. 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. If Contractor declines to include individuals or groups of providers in its network, Contractor must give the affected provider(s) written notice of the reason for its decision.

i. Contractor's provider selection policies and procedures must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. If Contractor declines to include individuals or groups of providers in its network, Contractor must give the affected provider(s) written notice of the reason for its decision.

Exhibit B –Statement of Work – Part III – Members

1. Informational Materials and Education of OHP Members

a. Contractor shall develop and provide informational materials and educational programs as described in OAR 410-141-0280, Oregon Health Plan Prepaid Health Plan Information Requirements and OAR 410-141-0300, Oregon Health Plan Prepaid Health Plan Member Education. These materials and programs shall be in a manner and format that may be easily understood and tailored to the backgrounds and special needs of OHP Members. Contractor shall develop, and make available to its OHP Members, a mental health education program that addresses Prevention and Early Intervention of mental illness. Contractor shall offer orientation to new OHP Members within 30 days of Enrollment that helps them understand the requirements and benefits of the plan. Contractor shall distribute an OHP Member handbook to new Enrollees within 14 calendar days of the OHP Member's effective date of coverage with Contractor, which includes, but is not limited to:

(1) Information about non-English language speaking Providers;

(2) Restrictions of freedom of choice among Providers;

(3) OHP Member rights and protections;

(4) Covered Services;

(5) Authorization requirements;

(6) After hours and emergency care;

(7) Specialty care;

(8) How to access other services not covered by Contractor;

(9) How to file a Grievance, Appeals and request an Administrative Hearing;

(10) How to request continuation of benefits pending the resolution of a Grievance, Appeal, or Administrative Hearing;

(11) Advance directives;

(12) Contractor's structure and operations; and

(13) Practitioner Incentive Plans.

(14) Information regarding OHP Member's possible responsibility for charges including Medicare deductibles and co-insurances (if they go outside of MHO for non-emergent care), copayments and charges for non-covered services.

Contractor shall provide written notice to OHP Members of any significant changes in program or policies and procedures at least 30 days before the intended effective date of the change.

b. Health education shall include: promotion and maintenance of optimal health care status to include identification of tobacco use, referral for tobacco cessation interventions (educations material, tobacco cessation groups, pharmacological benefits and the Oregon Tobacco Quit Line (1-877-270-STOP)).

c. Contractor shall give particular attention to the following requirements:

(1) Provide written information in each non-English language that is prevalent pursuant to OAR 410-141-0280 (2), in Contractor's Service Area;

(2) Make oral interpretation Services available free of charge to each OHP Member and Potential Enrollee, for any language. Notify OHP Members how to access those services and whom to contact to receive those services. This applies to all non-English languages not just those that the State identifies as prevalent;

(3) Make written information available in alternate formats, for any language, taking into consideration the special needs of OHP Members or Potential Enrollees. Notify OHP Members how to access those formats and whom to contact to receive those formats; and

(4) Notify OHP Members at least once a year of their right to request and obtain informational materials and who to contact to receive those services, for any language, as described in this section.

d. Contractor shall provide additional information that is available upon request by the OHP Member, including information on Contractor's structure and operations, and Practitioner Incentive Plans.

e. Contractor shall make available to OHP Members, or Potential Enrollees, in compliance with the requirements of the Americans with Disabilities Act of 1990, information in such alternative formats to allow the individual to effectively receive such information. These alternative formats may include, but are not limited to culturally appropriate information, foreign language translations, large print and audio of Braille translations for hearing or vision impaired OHP Members.

f. Contractor shall have written policies and procedures that meet the requirements for advance directives with respect to adult OHP Members receiving mental health services, as set forth in 42 CFR 422.128 and 42 CFR 489 Subpart I, which establishes, among other requirements, the requirements for compliance with Section 4751 of the Omnibus Budget Reconciliation Act of 1991 (OBRA). Contractor shall provide written information to adult OHP Members on advance directive policies within 14 calendar days of OHP Member's effective date of coverage with Contractor, which includes:

(1) their rights under State law (ORS 127.505 - 127.660); and

(2) Contractor's policies regarding the implementation of those rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience.

(3) The ability to file grievances with AMH concerning non-compliance with advance directive requirements.

The written information provided by Contractor must reflect changes in State law as soon as possible, but no later than 90 days after the effective date of any change to applicable State law.

2. OHP Member Rights

a. Contractor have written policies and procedures incorporating and ensuring the rights and responsibilities of OHP Members consistent with any applicable Federal and State laws, rules, and regulations that pertain to Enrollee rights, and shall ensure that Contractor's staff and Providers take those rights into account when furnishing services to OHP Members including, but, not limited to ORS 430.210, Rights of Service Recipients; Status of Rights; OAR 410-141-0320, Oregon Health Plan Prepaid Health Plan Member Rights and Responsibilities; ORS 430.735 through 430.765, Abuse Reporting for the Mentally Ill; and OAR 410-009-0050 through 410-009-0160, Abuse Reporting and Protective Services in Community Programs and Community Facilities.

b. Contractor shall provide OHP Members with information on the rights specified in OAR 410-141-0320, Oregon Health Plan Prepaid Health Plan Member Rights and Responsibilities. Contractor shall give particular attention to the following rights:

(1) The right to receive Covered Services;

(2) The right to receive information on available treatment options and alternatives presented in a manner appropriate to the OHP Member's condition and ability to understand;

(3) The right to be actively involved in the development of Treatment Plans if Covered Services are to be provided and to have parents involved in such Treatment Planning consistent with OAR 309-032-0950 through 309-032-1080, Standards for Community Treatment Services for Children; OAR 309-032-1100 through 309-032-1230, Intensive Treatment Services; and OAR 309-032-1240 through 309-032-1305, Intensive Community Based Treatment and Support Services;

(4) The right to participate in decisions regarding his or her health care, including the right to refuse Covered Services;

(5) The right to be informed as required in ORS 127.703, Required Policies Regarding Mental Health Treatment Rights Information; Declaration for Mental Health Treatment;

(6) The right to request and receive a copy of his or her own Clinical Record, (unless access is restricted in accordance with ORS 179.505 or other applicable law) and to request that the records be amended or corrected as specified in 45 CFR Part 164;

(7) The right to privacy and confidentiality and have Clinical Records kept confidential consistent with applicable Federal and State laws, rules and regulations.

(8) The right to have an opportunity to select an appropriate Mental Health Practitioner and Service site from within Contractor's Participating Provider Panel;

(9) The right to refer oneself directly to Contractor for Covered Services without first having to gain authorization from another Provider;

(10) The right to have access to Covered Services which at least equals access available to other persons served by Contractor;

(11) The right to receive a Notice of Action when a Service, benefit, Request for Service Authorization or Request for Claim Payment is denied; or prior to termination, suspension or reduction of a benefit or Service as described in Exhibit N, MHO Grievance System;

(12) The right to file Grievance or Appeal or request a hearing as described in Exhibit N, MHO Grievance System;

(13) The right to request an expedited Administrative Hearing if the OHP Member feels the mental health problem is Urgent or emergent and cannot wait for the normal hearing process;

(14) The right to request Continuation of Benefits until a decision in a hearing is rendered. The OHP Member may be required to repay any benefits continued if the issue is resolved in favor of Contractor;

(15) The right to receive, within 30 calendar days of Enrollment, written materials describing at least the following topics: rights and responsibilities, benefits available, how to access Covered Services, what to do in an Emergency Situation, and how to file a Grievance or Appeal, or request a hearing;

(16) The right to have written materials explained in a manner which is understandable;

(17) The right to access protective Services as described in ORS 430.735 through 430.765, Abuse Reporting for Mentally Ill and OAR 410-009-0050 through 410-009-0160, Abuse Reporting and Protective Services in Community Programs and Community Facilities;

(18) The right to be treated with respect and with due consideration for his or her dignity and privacy;

(19) The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

(20) The right to exercise his or her rights, and that the exercise of those rights does not adversely affect the way Contractor and its Providers treat the OHP Member.

c. Contractor shall post OHP Member rights in a visible location in all clinics, Participating Provider offices, and other Service locations.

3. Grievances System

a. Contractor shall have written procedures approved in writing by DHS for accepting, processing and responding to all Grievances and Appeals from OHP Members, consistent with the requirements of Exhibit N and OAR 410-141-0260 through 410-141-0266, including Grievances and Appeals related to requests for accommodation in communication or provision of Services for OHP Members with a Disability or limited English proficiency. AMH reviews the

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

b. Each time a Covered Service or benefit is 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 Action to the affected OHP Member at least 10 Business Days before the date of the Action, unless there is documentation that the OHP 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.

c. In the event an OHP Member or and OHP Member Representative requests an Administrative Hearing from AMH, Contractor will comply with the requirements of Exhibit N and OAR 410-141-0264, Administrative Hearings.

d. Contractor shall maintain a log of all OHP Member Grievances and Appeals. The log shall identify the OHP Member, the date of the Grievance, the resolution and the date of resolution. Contractor shall retain Grievance and Appeal logs for 7 years. This provision shall survive expiration or termination of the Agreement.

e. Contractor shall provide a quarterly report summarizing OHP Member Grievances, using the report format in Exhibit L.

f. Contractor and its Subcontractors shall cooperate with the DHS' Client Advisory Services Unit and the AMH's hearing representatives in all of DHS' activities related to OHP Member Grievances, Appeals, and Administrative Hearings.

g. Contractor shall inform OHP Members about the Contractor's Grievance and Appeal procedures and timeframes, the availability of assistance in the filing process, the toll-free numbers that an OHP Member can use to file a Grievance or Appeal by phone, how to request continuation of benefits (and OHP 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 OHP Member), and how to access a Administrative Hearing at the time of the OHP Member's Enrollment.

4. Enrollment and Disenrollment

a. Enrollment

(1) Enrollment is the process by which DHS signs on with a particular contractor those individuals who have been determined to be eligible for Services under the OHP Medicaid Demonstration Project and/or the SCHIP. Enrollment is voluntary, except in the case of mandatory Enrollment programs, pursuant to OAR 410-141-0060. DHS will sign on such individuals with contractor selected by the individual. If an eligible individual does not select a contractor, DHS may, pursuant to OAR 410-141-0060, Oregon Health Plan Managed Care Enrollment Requirements, elect to assign the person to a contractor selected by DHS. Contractor shall have an open Enrollment period at all times, during which Contractor shall accept, without restriction, all eligible individuals in the order in which they apply and are signed on with Contractor by DHS, unless

Contractor is also a FCHP and DHS and Contractor have jointly closed Enrollment because Contractor maximum Enrollment limit has been reached or for any other reason mutually agreed to by DHS and Contractor under the FCHP Agreement.

Contractor shall not discriminate, and shall not use any policy or practice that has the effect of discrimination against any individual eligible to enroll on the basis of mental health status or need for Covered Services, on the basis of other Disabling Conditions, or on the basis of race, color, or national origin.

(2) An individual becomes an OHP Member for purposes of this Agreement as of the date of Enrollment with Contractor, and as of that date, Contractor shall Provide all Covered Services to such individual as required by the terms of this Agreement. For persons who are enrolled on the same day as they are admitted to the hospital or, for children and adolescents admitted to psychiatric residential treatment services (PRTS), Contractor shall be responsible for said Services. If the person is enrolled after the first day of hospital stay or PRTS, the person shall be Disenrolled, and the date of Enrollment shall be the next available Enrollment date following discharge from hospital Services or PRTS.

(3) Enrollment of individuals with Contractor shall occur on a weekly and monthly basis as described in OAR 410-141-0060, Oregon Health Plan Managed Care Enrollment Requirements.

(4) DHS will make available to the Contractor Enrollment data files via an electronic mailbox. Enrollment data files on the electronic mailbox shall remain available until Contractor retrieves them, except where they remain for more than 6 (six) weeks. Any Enrollment data files remaining in the electronic mailbox for 6 (six) weeks or more may be removed at DHS' sole discretion. For the weekly Enrollment process, an Enrollment data file, which may contain new, current members with changes, and/or disenrolled OHP Members shall appear in the electronic mailbox Friday morning of each week. For the monthly Enrollment process, Enrollment data files, which may contain new, closed, members with changes and/or ongoing OHP Members for the next month shall appear on the electronic mailbox three business days following the date of monthly Enrollment cutoff. An Enrollment listing shall be made available to Contractor by the 5th of the month in which the Enrollments are applicable.

b. Disenrollment

(1) An individual is no longer an OHP Member eligible for Covered Services under this Agreement as of the effective date of the OHP Member's Disenrollment from Contractor, and as of that date, Contractor is no longer required to Provide Services to such individual under this Agreement.

(2) An OHP Member may be disenrolled from Contractor as follows:

(a) If requested orally or in writing by the OHP Member or Members Representative, as specified in OAR 410-141-0000 and 410-141-0080 (1) (b) for the following reasons:

(i) With cause:

(A) at any time

(B) if the Contractor does not, because of moral or religious objections, cover the Service the OHP Member seeks;

(C) if the OHP Member needs related Services to be performed at the same time and not all related Services are available within the Provider network and the OHP Member's primary care Provider or another Participating Provider receiving the Services separately would subject the OHP Member to unnecessary risk;

(D) for other reasons, including, but not limited to, poor Quality of Care, lack of access to services covered under this Agreement, or lack of access to Participating Providers experienced in dealing with the OHP Member's needs: or

(E) if the OHP Member moves out of Contractor's Service Area.

(ii) Without cause:

(A) after six months of Enrollment;

(B) whenever the OHP Member's eligibility is re-determined by DHS;

(C) if continued Enrollment would be detrimental to the OHP Member's health;

(D) the OHP Member is a Native American, Alaskan Native; or

(E) for Continuity of Care.

(b) If requested by Contractor because the OHP Member:

(i) is unruly or abusive to others;

(ii) threatens or commits an act of physical violence;

(iii) committed fraudulent or illegal acts such as permitting the use of OHP Member identification card by another person;

(iv) is suspected of altering a prescription;

(v) is suspected of thefts or other criminal acts committed in any Provider's or Contractor's premises;

(vi) otherwise misused the Medical Assistance Program;

(vii) is under the jurisdiction of the PSRB; or

(viii) for other reasons specified in OAR 410-141-0080.

(c) If requested by the PSRB for an OHP Member under its jurisdiction.

AMH approval is required for all Disenrollment requests of OHP Members, Contractor, or PSRB for OHP Members under PSRB jurisdiction.

(3) The effective date of Disenrollment shall be the first of the month following AMH approval for Disenrollment. If Contractor receives a request for Disenrollment from an OHP Member, Contractor shall forward the request to AMH within 10 business days. If AMH fails to make a Disenrollment determination by the first day of the second month following the month in which the OHP Member files a request for Disenrollment, the Disenrollment is considered approved. For OHP Members under PSRB jurisdiction who are approved for Disenrollment at the request of Contractor or PSRB, the effective date of Disenrollment may be made retroactive to the date the OHP Member was enrolled with Contractor or placed under PSRB jurisdiction, whichever is more recent.

(4) If DHS disenrolls an OHP Member retroactively, any Capitation Payments received by Contractor for that OHP Member after the effective date of Disenrollment shall be handled as described in Exhibit C, Section 5, Settlement of Accounts.

(5) Contractor shall not request Disenrollment of an OHP Member for reasons related to:

(a) An adverse change in the OHP Member's health status;

(b) A need for Services;

(c) Diminished mental capacity;

(d) Uncooperative or disruptive behavior resulting from the OHP Member's special needs (except when the continued Enrollment seriously impairs Contractor's ability to furnish Services to either the OHP Member or other OHP Members);

(e) A Disability or any condition that is a direct result of the OHP Member's Disability; or

(f) Other reasons specified in OAR 410-141-0080.

5. Identification Cards

DHS hereby waives the requirement that Contractor issue identification cards to OHP Members as specified in OAR 410-141-0300, Oregon Health Plan Prepaid Health Plan Member Education. Contractor may issue identification cards to OHP Members. Such identification cards shall be for Contractor's convenience only and shall confer no rights to Covered Services or other benefits under this Agreement. To be entitled to such Covered Services or benefits, the holder of the card must, in fact, be an OHP Member and be eligible for Covered Services under this Agreement. Each identification card shall indicate that the holder of the card is not entitled to benefits under this Agreement unless currently and lawfully enrolled as an OHP Member. If Contractor serves non-OHP Members, identification cards of non-OHP Members and OHP Members shall be as similar as possible and shall not distinguish the OHP Member as different in any way.

6. Marketing

Contractor must have in place a mechanism for OHP Members and Potential Enrollees to receive information to help them understand the requirements and benefits available under this Agreement. Contractor shall have information available for Potential Enrollees to assist them in making an informed decision about Enrollment with Contractor. Contractor shall ensure that staff activities and written materials are accurate and do not intentionally mislead confuse, or defraud OHP Members or Potential Enrollees about options available through Contractor. Statements that will be considered inaccurate, false, or misleading include, but are not limited to, any assertion or statement (whether written or oral) that the OHP Member must enroll with Contractor in order to obtain benefits or in order not to lose benefits; or that the Contractor is endorsed by CMS, the federal or state government, or similar entity. Pursuant to OAR 410-141-0270, Contractor shall cooperate with AMH in developing written materials to be included in OHP Medicaid Demonstration Project and SCHIP application packets.

a. Contractor, and Subcontractors, shall not initiate contact nor market independently to Potential Enrollees in an attempt to influence an individual's Enrollment with Contractor, without the express written consent of AMH.

b. Pursuant to OAR 410-141-0270(1), Contractor and Subcontractors may not conduct, directly or indirectly, door-to-door, telephonic, mail or other cold call marketing practices to entice Potential Enrollees to enroll with Contractor, or to not enroll with another Contractor.

c. Contractor, and Subcontractors, shall not seek to influence an individual's Enrollment with the Contractor in conjunction with the sale of any other insurance.

d. Contractor and Subcontractors may engage in activities intended to Provide Outreach to Contractor's enrolled OHP Members for the purpose of enhancing mental health promotion or education within Contractor's Service Area.

e. Contractor shall submit to AMH, for review and approval, all written marketing materials to OHP Members or Potential Enrollees that reference benefits and/or coverage. Marketing material shall be made available to all OHP Members, or Potential Enrollees, within Contractor's Service Area. Marketing materials expressly for the purpose of mental health promotion, education or Outreach do not require prior approval.

Exhibit B –Statement of Work – Part IV – Financial Matters

1. Financial Risk, Management and Solvency

Contractor shall assume the risk for providing Covered Services to its OHP Members. Contractor shall provide assurances to AMH that Contractor's provision(s) against the risk of Insolvency are adequate to ensure that OHP Members will not be liable for Contractor's debts if Contractor becomes insolvent. Contractor shall maintain risk protection against catastrophic or unexpected OHP Member expenses related to Covered Services, and shall maintain protections against Insolvency, as specified in Exhibit G, Solvency Plan and Financial Reporting. If Contractor expects to change any elements of the Solvency Plan or solvency protection arrangements, Contractor shall provide written advance notice to AMH at least sixty (60) calendar days before the proposed effective date of change. Such changes are subject to written approval from AMH.

a. Failure to maintain adequate financial Solvency, as determined by DHS, shall be grounds for termination of this Agreement by DHS.

b. In the event that Insolvency occurs, Contractor remains financially responsible for providing Covered Services for OHP Members through the end of the period for which Contractor has been paid, including inpatient admissions up until date of discharge, except for persons approved for Long Term Psychiatric Care as defined in Exhibit B, Part II, Section 1, Subsection c, Paragraph (9) of this Agreement.

c. OHP Member shall not be held liable and Contractor shall not bill, charge, seek compensation, remuneration, or reimbursement from any OHP Member for:

1. any debt or payment of claims due to Contractor's Insolvency;

2. Covered Services provided to the OHP Member for which DHS did not pay Contractor;

3. Covered Services provided to the OHP Member by a Provider under a contractual, referral, or other arrangement for which Provider did not receive payment from Contractor; or

4. Payment for Covered Services provided under a contract, referral, or other arrangement, other than co-payments, if applicable.

d. Contractor shall not seek recourse against DHS for Covered Services provided during the period for which Capitation Payments were made by DHS to Contractor even in the event Contractor becomes insolvent.

2. Dual Payment

Except as specifically permitted by this Agreement, Contractor shall not be compensated for work performed under this Agreement from any other department of the State of Oregon, nor from any other source including the federal government. Contractor shall immediately report any funds received by Contractor through activities arising under this Agreement.

3. (Reserved)

Exhibit B –Statement of Work – Part V – Operations

1. Recordkeeping

a. Clinical Records

Contractor shall maintain recordkeeping consistent with OAR 410-141-0180, Oregon Health Plan Prepaid Health Plan Recordkeeping. Clinical Records shall document the degree of agreement or disagreement of the OHP Member, or the legal guardian of the OHP Member, with the Covered Service and Treatment Plans recommended and explained by the Mental Health Practitioner. If the Clinical Record does not include a signed and dated consent of the OHP Member or the legal guardian of the OHP Member to the recommended Covered Service or Treatment Plan, the Clinical Record shall document the reason such signature is missing. Clinical Records shall also include the signatures, signature dates, and academic degrees of all persons providing Covered Services and, if applicable, the signatures, signature dates, and academic degrees of all persons providing clinical, medical or direct supervision of the case.

b. Financial Records

Contractor shall maintain complete and legible financial records pertinent to Covered Services delivered and Capitation Payments received. Such records shall be maintained in accordance with accounting principles approved by the American Institute of Certified Public Accountants, Generally Accepted Accounting Principles (GAAP), and/or other applicable accounting guidelines such as those outlined in OMB circulars A-87 and A-122. Financial records shall be retained for at least five (5) years after final payment is made under this Agreement or until all pending matters are resolved, whichever period is longer. Contractor shall maintain an appropriate record system for Services to enrolled members and retain records in accordance with 45 CFR Part 74, unless otherwise specified in applicable Oregon Revised Statutes or Oregon Administrative Rules.

c. Government Access to Records

Contractor shall provide, CMS, the Comptroller General of the United States, the Oregon Secretary of State, the Oregon Department of Justice Medicaid Fraud Control Unit, DHS and all their duly authorized representatives the right of access to facilities and to financial (including all accompanying billing records), clinical, and personnel records and other books, documents, papers, plans and writings of Contractor, to its Subcontractors, that are pertinent to this Agreement to perform examinations and audits and make excerpts and transcripts. Contractor shall retain and keep accessible all financial and personnel records and books, documents, papers, plans, and writings for a minimum of three (3) years, or such longer period as may be required by applicable law, following final payment and termination of this Agreement, or until the conclusion of any audit, controversy or litigation arising out of or related to this Agreement, whichever date is later. Contractor shall, upon request and without charge, provide a suitable work area and copying capabilities to facilitate such a review or audit.

2. Contractually Required Reports, Policies and Procedures

Contractor shall submit timely, accurate and complete reports as follows:

The reports listed with an asterisk (*) need only to be submitted by Contractor for initial review and approval by AMH. For subsequent AMH reviews of these same policies, procedures and reports, Contractor shall submit Schedule 5, signing the affirmation that these documents have been approved during a previous contract year and that no revisions have occurred since the initial submission and AMH approval.

a. Reports Initially Due on Effective Date of this Agreement

(1) List of Delegated Activities (other than direct services) and the Entities Performing the Delegated Activities.

(a) See Exhibit D, Section 16, Subsection g.

(b) Submission is due on the effective date of this Agreement.

(2) Practitioner Incentive Plan

(a) See Exhibit M.

(b) Submission is due on the effective date of this Agreement,
45 calendar days before a change in scope of work,
Within 30 calendar days of AMH request, and
As of the effective date of an amendment extending the Service Area.

(3) *Grievance Systems, including Member Appeal Form and Notice of Denial Letter

(a) See Exhibit B, Part III, Section 3.

(b) Submission due by the effective date of this Agreement or through affirmation and submission of Schedule 5 and 5.1.

(4) *Third Party Resources and Personal Injury Lien Policy and Procedures

(a) See Exhibit I

(b) Submission due by the effective date of this Agreement or through affirmation and submission of Schedule 5 and 5.1.

(5) *Utilization Management Policies and Procedures

(a) See Exhibit B, Part I, Section 1, Subsection h, Paragraph (3)

(b) Submission due on the effective date of this Agreement or through affirmation and submission of Schedule 5 and 5.1.,
Within 45 calendar days of change or adoption, and
Within 30 calendar days of AMH request.

(6) *OHP Member Information Materials, including Member Handbook and Annual Notification to OHP Members Regarding Ability to Participate in Activities of Contractor

(a) See Exhibit B, Part III, Section 1 and Exhibit B, Part II, Section 1, Subsection c, Paragraph (10).

(b) Submission due on effective date of this Agreement or through affirmation and submission of Schedule 5 and 5.1., and
Upon changes – within 30 days before the intended change requiring revision.

(7) Mental Health Services Capacity Assurance Report

(a) Contractor shall submit to AMH, the Mental Health Services Capacity Report, in a format as negotiated by both parties and as described in Exhibit K. It is AMH's intent to incorporate the negotiated specifications for a standardized format by amendment to this Agreement.

(b) Submission due at the time it enters into a contract with DHS,
Submission due one calendar month following the effective date of this Agreement,
Submission due 14 days prior to the effective date of a significant change that would affect adequate Capacity and Services,
Submission due 30 days prior to the effective date of a change in Contractor's services, benefits, geographic Service Area or payments, and
Submission due within 30 days of the effective date of enrollment of a new population.

b. Reports Due within 30 Days of Effective Date of this Agreement

(1) Proof of Excess Loss Protection/Stop Loss

(a) See Exhibit G.

(b) Submission due within 30 days of effective date of this Agreement

(2) Key Personnel

Contractor shall submit to AMH, within 30 days following the effective date of this Agreement, and immediately following any changes, the names and contact numbers for the following key personnel: Contract Liaison, QA/PI Liaison, Grievance, Appeals and Hearing Liaison, and Long Term Psychiatric Care Liaison.

(a) See Schedule 6

(b) Submission due within 30 days of effective date of this Agreement and immediately following changes.

(3) *Objections to Services Based on Moral or Religious Grounds

(a) See Exhibit B, Part I, Section 1, Subsection d, Paragraph (9).

(b) Submission due upon application of Medicaid contract, within 30 days of effective date of this Agreement, upon changes of Contractor policy or by affirmation and submission of Exhibit P.

(4) *Policy and Procedure: CASII Administration

(a) See Exhibit B, Part II, Section 1, Subsection b (8) (c) (vii).

(b) Submission due within 30 days of effective date of this Agreement or by affirmation and submission of Schedule 5 and 5.1.

(5) *Policy and Procedure for Level of Need Determination

(a) See Exhibit B, Part II, Section 1, Subsection b (8) (c) (vi).

(b) Submission due on effective date of this Agreement or through affirmation and submission of Schedule 5 and 5.1.

(6) *Policy and Procedure for Prevention and Detection of Fraud and Abuse

(a) See Exhibit J

(b) Submission due within 30 days of effective date of this Agreement or by affirmation and submission of Schedule 5 and 5.1.

(7) Enrollment Validation Signature Authorization Form ,

a) See Exhibit H- Attachment 1, Report Form H.1

b) Submission due within 30 days of effective date of this Agreement.

c. Reports Due within 45 Days of the Effective Date of this Agreement

a) QA/PI Work Plan

(a) See Exhibit B, Part II, Section 3, Subsection b.

(b) Submission due within 45 days of the effective date of this Agreement.
(c) AMH shall review the Work Plan within 30 days of receipt.

c. Fiscal Year End Reporting

(1) Annual Audited Financial Report

(a) See Exhibit G.

(b) Submission due within 180 calendar days from the end of the Contractor fiscal year.

(2) G.5: Fiscal Year Cash Flow Analysis

(a) See Exhibit G.

(b) Submission due within 90 calendar days following the end of the Contractor's fiscal year.

(3) G.4: Statement of Revenue and Expenses (Annual Fiscal Year)

(a) See Exhibit G

(b) Submissions due 60 calendar days following the end of the fiscal year.

d. Reports due within 60 calendar days following the end of each calendar quarter

(1) Evidence of Restricted Reserve

(a) See Exhibit G.

(b) Submission due within 60 calendar days following the end of each calendar quarter: 06-01, 09-01, 12-01, 03-01.

(2) G.2 Third Party Resource Collections

(a) See Exhibit G

(b) 60 calendar days following the end of each calendar quarter 06-01, 09-01, 12-01, 03-01

(3) G.3 Quarterly Balance Sheet

(a) See Exhibit G

(b) 60 calendar days following the end of each calendar quarter 06-01, 09-01, 12-01, 03-01

(4) G.4 Contractors Quarterly Statement of Revenue and Expenses

(a) See Exhibit G

(b) 60 calendar days following the end of each calendar quarter 06-01, 09-01, 12-01, 03-01

(5) G.4A Health Care Expenses By Service Type

(a) See Exhibit G

(b) 60 calendar days following the end of each calendar quarter06-01, 09-01, 12-01, 03-01

(6) G.4B Prevention/Education/Outreach (PEO)

(a) See Exhibit G

(b) 60 calendar days following the end of each calendar quarter 06-01, 09-01, 12-01, 03-01

(7) MHO Grievance Log

(a) See Exhibit B, Part III, Section 3 and Exhibit L.

(b) 60 calendar days following the end of each calendar quarter 06-01, 09-01, 12-01, 03-01

(8) Level of Need Determination

(a) See Schedule 4

(b) 60 calendar days following the end of each calendar quarter 06-01, 09-01, 12-01, 03-01

e. Due After Termination of this Agreement

(1) QA/PI Work Plan Report

(a) See Exhibit B, Part II. Section 3, Subsection b, Paragraph (iii)

(b) Submission due 45 days after termination of the MHO Agreement for the current contract cycle.

f. Encounter Data

(1) See Exhibit H and forms H.1, H.2 and H.3

(2) Submission due within 180 calendar days of the date of Services, and Corrections due within 63 calendar days of DMAP notice of a pended Encounter

g. Report Form H.1, Signature Authorization Form

(1) See Exhibit H.1

(2) Submission due within 30 days of effective date of this Agreement Immediately upon changes thereafter

h. Report Form H.2 –Data Certification and Validation Report Form

(1) Form must be submitted concurrently with each Encounter Data submission

i. Report Form H.3 - Claim Count Verification Acknowledgement and Action Form

(1) Form must be completed as an acknowledgement and action Form and return I to Contractor's designated Encounter Data Liaison within ten (10) Business Days of receipt of the Out of Balance Data Validation.

j. Client Process Monitoring System

(1) See Schedule 1

(2) Submission due within 30 calendar days of initiation of Services and within 30 calendar days of termination of Services.

k. Oregon Patient/Resident Care System

(1) See Schedule 3

(2) Submission due within 12 hours of admission to Acute Care Inpatient Hospital Psychiatric Care

3. Other Reporting Requirements

a. Abuse Reporting and Protective Services

For adult OHP Members, Contractor and Participating Providers shall comply with all protective Services, investigation and reporting requirements described in OAR 410-009-0050 through 410-009-0160, Abuse Reporting and Protective Services in Community Programs and Community Facilities and ORS 430.735 through 430.765, Abuse Reporting for Mentally Ill.

b. Failure to Comply with Data Submission Requirements

Contractor's failure to submit data in accordance with this Agreement shall be considered in noncompliance with the terms of this Agreement and shall be grounds for withholding Capitation Payments as specified in Exhibit B, Part VI, Section 2, Remedies Short of Termination.

c. Other Systems

Contractor shall maintain a health information system that collects, analyzes, integrates, and reports data. Contractor shall make collected data available to the State or CMS upon request. The system will have automated capacity adequate to track changes to and errors in the Enrollment listing, including capability to track Disenrollments for other than loss of Medicaid eligibility; track Utilization Management activities; Grievances and Appeals; coordinate benefits with other payers; collect funds from other payers; and track claims received, adjudicated and paid.

d. Executive Compensation Reporting

The Parties shall amend this Agreement 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).

4. Research, Evaluation and Monitoring

a. In addition to submission of data described in Exhibit B, Part V, Section 3, Data Systems, Contractor shall cooperate with AMH in collection of information through Consumer surveys, on-site reviews, medical chart reviews, financial reporting and financial record reviews, interviews with staff, and other information for the purposes of monitoring compliance with this Agreement, verification of Services actually provided, and for developing and monitoring performance objectives. Contractor shall assist AMH with development and distribution of survey instruments for use in evaluating integration of Covered Services in the OHP Medicaid Demonstration Project and SCHIP. Contractor and its Subcontractors shall provide access to records and facilities as described in OAR 410-141-0180, Oregon Health Plan Prepaid Health Plan Recordkeeping, Exhibit B, Part V, Section 1, Recordkeeping and Exhibit B, Part VI, Section 24, AMH Compliance Review and Quality Assurance Monitoring.

b. Contractor shall assist AMH in developing detailed procedures for tracking and evaluating potential adverse selection created by the urban and/or rural environment, as applicable. Contractor shall work with AMH to assure that such procedures include collection and evaluation of information that will enable AMH to compare the intensity of Covered Services rendered to OHP Members of different Mental Health Organization models.

c. Contractor, or its Subcontractors and Providers shall cooperate with DHS for an annual external, independent professional review of the quality outcomes and timeliness of and access to services provided in this Agreement as indicated in Exhibit B, Part II, Section 3.

Exhibit B –Statement of Work – Part VI – Relationship of Parties

1. AMH Compliance Review and Quality Assurance Monitoring

a. AMH will conduct Agreement compliance and QA monitoring related to this Agreement. Contractor and its Subcontractors shall cooperate in such monitoring and Contractor shall notify its Subcontractors and Participating Providers of such monitoring, related instructions and request for information.

b. AMH will provide Contractor thirty (30) calendar days written notice of any Agreement compliance and QA monitoring activity which requires any action or cooperation of Contractor as specified in D., below, unless one of the following conditions exist or is suspected to exist:

(1) Operations of Contractor or its Subcontractors or Participating Providers threaten the health or safety of any OHP Member; or

(2) Contractor or its Subcontractors or Participating Providers may act to alter records or make then unavailable for inspection.

c. Notice of monitoring shall include the date the monitoring shall occur, names of individuals conducting the monitoring, and instructions and requests for information.

d. Monitoring procedures may include, but are not limited to, the following:

(1) Entry and inspection of any facility used in the delivery of Covered Services;

(2) A request for submission to AMH of copies of documents, or access to such documents during a site visit, as needed to verify compliance with this Agreement or state and federal laws, rules and regulations;

(3) The completion by Contractor of self-assessment checklist or pre-site visit questionnaires recording the degree of compliance or noncompliance with specific Agreement or rule requirements; and

(4) Conduct of interviews with, and administration of questionnaires to Contractor staff, Participating Providers, Health Care Professionals, Local and/or Regional Allied Agencies, and Consumers knowledgeable of Service operations.

e. Contractor shall cooperate with AMH in the development of a corrective action plan to bring Contractor performance in compliance with this Agreement or state and federal laws, rules and regulations.

f. AMH will make available to Contractor a written report of its findings and conclusions within sixty (60) calendar days of the completion of the monitoring.

2. Remedies Short of Termination

a. Whenever AMH, in its sole judgment, determines that Contractor is out of compliance with this Agreement, AMH may, at its discretion, take Remedial Action as outlined in policies adopted by AMH. The policies shall be provided to Contractor as adopted by AMH. AMH shall issue a Notice of Intended Remedial Action which provides, in non-Emergency Situations, at least thirty (30) calendar days' notice prior to the effective date of the Remedial Action, and in Emergency Situations, at least seven (7) calendar days' notice prior to the effective date of Remedial Action. Contractor may request an administrative review concerning the Notice of Intended Remedial Action and may also request suspension of the Remedial Action until a decision is reached through the administrative review process. To receive a suspension of the intended Remedial Action, Contractor must request an administrative review before the effective date of the intended Remedial Action and include a request to suspend the intended Remedial Action. If the intended Remedial Action is suspended and a decision is reached in favor of AMH, AMH may impose the Remedial Action retroactively to the effective date stated in the Notice of Intended Remedial Action.

b. Remedial Action provides for a range of options of varying severity depending on the seriousness and nature of the Agreement violation. Options include suspension or freezing of Enrollment, financial withholds, or other sanctions designed to remedy Agreement violations. Conditions that may result in Remedial Action include, but are not limited to:

(1) Failure to substantially Provide Medically Appropriate Services that are required to be provided to OHP Members under this Agreement;

(2) Contractor acts to discriminate among OHP Members on the basis of their mental health status or need for mental health Services;

(3) Misrepresentation or falsification of information that Contractor provides to an OHP Member or OHP Member Representative, Potential Enrollee, Provider, CMS or DHS;

(4) Failure to comply with the requirements for physician incentive plans;

(5) Failure to provide a Provider Panel sufficient to ensure adequate Capacity to Provide Medically Appropriate Covered Services in accordance with access requirements specified in this Agreement;

(6) Failure to maintain an internal QA/PI program;

(7) Failure to comply with the operational and financial reporting requirements specified in this Agreement;

(8) Failure to comply with Fraud and Abuse requirements;

(9) Failure to make timely claims payments to Providers or provide timely approval of authorizations;

(10) Failure to comply with Encounter Data submission requirements specified in this Agreement;

(11) Distribution directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved by AMH or that contain false or materially misleading information;

(12) Violation of any of the other applicable requirements of sections 1903(m) or 1932 of the Social Security Act and any implementing regulations.

c. AMH will provide CMS written notice whenever it imposes or lifts Remedial Action no later than 30 days after the date the Remedial Action is taken or removed. Notification to CMS will include the type of Remedial Action and the reason for the decision to impose or lift a Remedial Action. Payment for the new OHP Member will be denied when, and for so long as, payment to those OHP Members is denied by CMS.

Exhibit C – Consideration

1. Payment Types and Rates

a. In consideration of all work to be performed by Contractor under this Agreement, DHS will pay Contractor a monthly Capitation Payment for each OHP Member, for the period beginning on the date of Enrollment and ending on the date of Disenrollment. Contractor shall be paid a Capitation Payment only for those OHP Members who are enrolled with Contractor according to DHS records. Where the date of an OHP Member's Enrollment or Disenrollment is during mid-month, the Capitation Payment for that OHP Member shall be prorated. DHS may withhold payment for new Enrollees when, and for so long as, DHS determines that Contractor meets the circumstances cited in 42 CFR 434.67. Contractor shall be responsible for all federal and state taxes applicable to compensation or payments paid to Contractor under this Agreement and, unless Contractor is subject to backup withholding, DHS will not withhold from such compensation or payments any amounts to cover Contractor's federal or state tax obligations. Contractor is not eligible for any social security, unemployment insurance or workers' compensation benefits from compensation or payments paid to Contractor under this Agreement, except as a self-employed individual.

(1) For each month during the designated period, for the tables contained in Attachment 2, to this Exhibit C, DHS will pay Contractor the Capitation amount listed for each OHP Member falling within the designated rate category/county who is enrolled with Contractor for the full month. For any month when one or more OHP Members are enrolled for only part of the month, the Capitation amount for each OHP Member shall be prorated based upon the number of days such OHP Member is enrolled during the month.

(a) DHS has developed actuarially set Adjusted Per Capita Costs necessary to cover the reasonable costs of the services to be provided under this Agreement. A full description of the methodology used to calculate per capita costs and Capitation Payments may be found in the documents described in Attachment 2, to this Exhibit C.

(b) DHS will provide, upon Contractor request, and when available, documents produced by the actuarial firm which document and describe the Capitation rate development process.

2. Payment In Full

The consideration listed in Attachment 2, to this Exhibit C is the total consideration payable to Contractor for all work performed under this Agreement.

3. Changes in Payment Rates

The Capitation Payment may be changed by amendment to this Agreement pursuant to Exhibit D, Section 10, Termination and Section 18, Amendments, of this Agreement, except that changes in Covered Services in response to revisions in the Prioritized List of Health Services by the HSC that would have an actuarial impact, as determined by DHS, on Contractor's projected costs greater than 1% or in response to action by the Oregon Legislative Assembly shall be made as follows:

a. DHS will notify Contractor within thirty (30) calendar days of any action by the HSC under ORS 414.720 or the Legislative Assembly that will necessitate a change in the Capitation Payment.

b. In the event of any action as described in Exhibit C, Section 3, Changes in Payment Rates, Subsection a, DHS will prepare and provide to Contractor an amendment to this Agreement. The new Capitation Payment under such amendment shall take effect no earlier than thirty (30) calendar days from the date the amendment is mailed or delivered to Contractor and, no earlier than sixty (60) calendar days following final legislative action.

c. Contractor shall sign any such amendment within forty-five (45) calendar days of receipt of the amendment, or such later date as DHS may specify. If Contractor fails to sign the amendment within such time period, DHS may, at its sole discretion, terminate this Agreement, effective on the proposed effective date of the amendment or such later date as DHS may specify.

d. No amendment to this Agreement shall be effective and binding until it has been signed by all parties and all necessary State of Oregon approvals have been obtained.

4. Timing of Capitation Payments

a. The date on which DHS will process Capitation Payments will depend on whether the Enrollment occurred on a weekly or monthly basis. For OHP Members enrolled with Contractor during a weekly Enrollment cycle, Capitation Payments will be mailed to Contractor by the first working day following the date of Enrollment. For OHP Members enrolled with Contractor during a monthly Enrollment cycle, Capitation Payments will be made available to Contractor by the 10th day of the month to which such payments are applicable. Both sets of payments will appear on the monthly remittance advice.

b. DHS will also send Contractor an Enrollment listing by the 5th day of each month. If Contractor believes that there are any errors in the remittance advice, Enrollment data files, or Enrollment listing, Contractor shall notify DHS. Except for newborns and notwithstanding any errors in the remittance advice, Enrollment data files, or Enrollment listing, retroactive Capitation Payments shall not be made to Contractor for OHP Members not appearing on Contractor's Enrollment data files or listing.

c. All FFS claims must be billed by Contractor, its Subcontractor, or its Participating Providers directly in accordance with OAR 410-141-0420, Billing and Payment Under the Oregon Health Plan. Billing Providers must be enrolled with DHS in order to receive payment. Contractor shall not submit any FFS claims for any Covered Services provided to OHP Members.

5. Settlement of Accounts

a. If an OHP Member is disenrolled, DHS may Recoup or Contractor shall refund to DHS, Capitation Payments received for the OHP Member for any period after the Disenrollment date.

b. DHS will have no obligation to make any payments to Contractor for any period(s) during which Contractor substantially fails to carry out the terms of this Agreement. Any payments received by Contractor from DHS for such periods, and any other payments received by Contractor from DHS to which Contractor is not entitled under the terms of this Agreement, will be considered an overpayment and will be recovered from Contractor.

c. Any Capitation Payments received by Contractor that are considered an overpayment may be offset by any future payments to which Contractor would be entitled under DHS rules for any Covered Services provided by Contractor.

Exhibit C – Consideration – Attachment 1 - Calculation of Capitation Payments

1. The LBMPY area includes ***[Name of County(ies)]*** Counties.

2. The Other area contains ***[Name of County(ies)]***Counties.

3. Calculation of Capitation Payments

   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

[Plan Specific Rates Inserted Here]

Exhibit D – Standard Terms and Conditions

1. Controlling State Law/Venue

This Agreement shall be governed and construed in accordance with the laws of the State of Oregon, without regard to principles of conflicts of laws. Any action or suit involving this Agreement shall be filed and tried in Marion County, Oregon. Provided, however, if the action or suit might be brought in a federal forum, then it shall be brought and conducted solely and exclusively with the United States District Court for the District of Oregon. Nothing herein shall be constituted as a waiver of the State's sovereign or governmental immunity, whether derived from the Eleventh Amendment to the United States Constitution or otherwise, or of any defenses to claims or jurisdictions based thereon. Contractor, by signature below if its authorized representative, hereby consents to the in personam jurisdiction of said court.

2. Compliance with Applicable Laws

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 provisions of prepaid capitated health care and services, OAR Chapter 410, Division 141; (iv) all other DHS Rules in OAR Chapter 410; and (v) all DHS Rules in OAR Chapter 309. 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 Agreement,

(2) this Agreement, 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 Agreement, be qualified, professionally competent, and duly licensed to perform the Work, and

(5) Contractor prepared its application related to this Agreement, 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

DHS certifies at the time this Agreement is signed that sufficient funds are available and authorized for expenditure to finance costs of this Agreement within DHS current appropriation or limitation. Contractor understands and agrees that DHS payment amounts under this Agreement attributable to work performed after the last day of the current biennium is contingent upon DHS receiving appropriations, limitations, or other expenditure authority sufficient to allow DHS, in the exercise of its reasonable administrative discretion, to continue to make Capitation Payments under this Agreement. In the event the Oregon Legislative Assembly fails to approve sufficient appropriations, limitations, or other expenditure authority for the succeeding biennium, DHS may terminate this Agreement effective upon written notice to Contractor with no further liability to Contractor.

6. Ownership

Contractor shall notify AMH of any changes in the ownership of Contractor and provide AMH 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.

7. Indemnification

CONTRACTOR SHALL DEFEND, SAVE, HOLD HARMLESS AND INDEMNIFY THE STATE OF OREGON, DHS AND THEIR OFFICERS, AGENTS, EMPLOYEES, FROM AND AGAINST ALL CLAIMS SUITS, ACTIONS, DAMAGES, LIABILITIES, COSTS AND EXPENSES OF WHATSOEVER NATURE RESULTING FROM, ARISING OUT OF, OR RELATING TO THE ACTIVITIES OR OMISSIONS OF CONTRACTOR OR ITS OFFICERS, EMPLOYEES, AGENTS OR SUBCONTRACTORS UNDER THIS AGREEMENT. IF CONTRACTOR IS A COUNTY (AS THE

WORD "COUNTY" IS USED IN ARTICLE XI, SECTION 10 OF THE OREGON CONSTITUTION) AND A PUBLIC BODY (AS "PUBLIC BODY" IS DEFINED IN ORS 30.260(4)), CONTRACTOR'S LIABILITY UNDER THIS AGREEMENT IS SUBJECT TO THE LIMITATIONS OF THE OREGON TORT CLAIMS ACT AND OF ARTICLE XI, SECTION 10 OF THE OREGON CONSTITUTION.

TO THE EXTENT PERMITTED BY ARTICLE XI, SECTION 7 OF THE OREGON CONSTITUTION AND BY THE OREGON TORT CLAIMS ACT, DHS SHALL INDEMNIFY, WITHIN THE LIMITS OF THE OREGON TORT CLAIMS ACT, CONTRACTOR AGAINST LIABILITY FOR DAMAGE TO LIFE AND PROPERTY ARISING FROM DHS ACTIVITIES UNDER THIS AGREEMENT, PROVIDED DHS SHALL NOT BE REQUIRED TO INDEMNIFY CONTRACTOR FOR ANY SUCH LIABILITY ARISING OUT OF THE WRONGFUL ACTS OF CONTRACTOR OR THE EMPLOYEES, AGENTS, OR SUBCONTRACTORS 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 Agreement 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 AMH's notice or such longer period as AMH may specify in such notice;

(3) Contractor commits any material breach or default of any covenant, warranty, obligation or certification under this Agreement, 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 Agreement in accordance with its terms, and such breach, default or failure is not cured within ten (10) Business Days after delivery of AMH's notice or such longer period as AMH 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 Agreement, 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 Agreement 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; o

(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 AMH determines that health or welfare of OHP Members is in jeopardy if this Agreement continues; or

(6) If AMH Determines:

(a) That amendment of this Agreement 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 Agreement to execute those changes in the time and manner proposed in the amendment may place AMH 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 this Agreement within the time allowed.

b. Default by AMH

AMH shall be in default under this Agreement if:

(1) AMH fails to pay Contractor any amount pursuant to the terms of this Agreement, and AMH 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) AMH commits any other material breach or default of any covenant, warranty, or obligation under this Agreement, fails to perform its commitments hereunder within the time specified or any extension thereof, and AMH 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. AMH's Remedies

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

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

(2) Withholding payments under Exhibit C, for Work that has not met AMH's approval or the service levels set forth in this Agreement;

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

(4) Exercise of its right of setoff.

These remedies are cumulative to the extent the remedies are not inconsistent, and AMH 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, the rights and obligations of the parties shall be the same as if this Agreement was terminated pursuant to Exhibit D, Section 10 Subsection a. (1).

b. Contractor's Remedies

In the event AMH terminates this Agreement for convenience under Exhibit D, Section 10, or in the event AMH is in default under Exhibit D, Section 8 and whether or not Contractor elects to exercise its right to terminate this Agreement 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 AMH 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 AMH upon written demand.

10. Termination

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

(1) This Agreement may be terminated by mutual consent of both parties or by either party upon thirty (30) calendar days written notice. If termination is initiated by Contractor, DHS has a right to full disclosure of Contractor's records required by this Agreement. Contractor shall promptly provide such disclosure to DHS upon demand. If termination is initiated by DHS under Exhibit C, Section 3, Changes in Payment Rates, the thirty (30) calendar days notice period does not apply and the termination is effective upon written notice to Contractor.

(2) DHS may also terminate this Agreement effective upon delivery of written notice to Contractor, or at such later date as may be established by DHS, as set forth elsewhere in this Agreement, under any of the following conditions:

(a) If DHS funding from federal, state or other sources is not obtained, or is withdrawn, reduced or limited, or if DHS expenditures are greater than anticipated, such that funds are insufficient to allow for the purchase of Services as required by this Agreement.

(b) If federal or state regulations or guidelines or CMS waiver terms are modified, changed or interpreted in such a way that the Services are no longer allowable or appropriate for purchase under this Agreement or are no longer eligible for the funding proposed for payments under this Agreement.

(c) If any license, registration or certificate required by law or regulation to be held by Contractor or Contractor's Subcontractors or Participating Providers to Provide Covered Services is for any reason denied, revoked or not renewed.

(d) If AMH determines that the health or welfare of OHP Members is in jeopardy should this Agreement continue.

(e) If Contractor fails to Provide Services called for by this Agreement, fails to perform any other provisions of this Agreement within the time specified or any extension thereof, or fails to pursue the work of this Agreement in accordance with its terms; and such failure continues for ten (10) calendar days, or such longer period as AMH may authorize, after Contractor's receipt of written notice thereof.

(f) If Contractor fails to perform or otherwise comply with any provision contained in Exhibit B, Statement of Work.

(g) If Contractor is a Fully Capitated Health Plan and no longer provides Services under the OHP Medicaid Demonstration Project in all of the counties listed in Part IV Service Area, pursuant to its FCHP Service agreement with DHS.

(h) If Contractor is a county government (or a group of counties acting through a lead county under ORS Chapter 190 or an intergovernmental entity created by a group of counties under ORS Chapter 190) and no longer operates or contracts for CMHPs (or in the case of a group of counties acting through a lead county under ORS Chapter 190 or an intergovernmental entity created by a group of counties under ORS Chapter 190, one or more of the said counties no longer operates or contracts for CMHPs) pursuant to ORS 430.620 under an Intergovernmental Agreement with DHS.

b. Before terminating an MCO or PCCM Contract under 42 CFR 438.708, DHS must provide the entity a pre-termination hearing. DHS must:

(1) Give the MCO or PCCM written notice of its intent to terminate, the reason for termination, and the time and place of the hearing;

(2) Give the entity (after the hearing) written notice of the decision affirming or reversing the proposed termination of this Agreement, and for an affirming decision, the effective date of termination; and

(3) For an affirming decision, give Enrollees of the MCO or PCCM notice of the termination and information, consistent with 438.10, on their options for receiving Medicaid services following the effective date of termination.

c. Notwithstanding Paragraphs (1) and (2) of this subsection, if DHS initiates termination of this Agreement, Contractor may request an Agreement pre-termination hearing within ten (10) days of the Notice of Termination as follows:

(1) An Agreement pre-termination hearing allows an opportunity for the Administrator of DHS, or designee, to reconsider the decision to terminate this Agreement. The request for an Agreement pre-termination hearing may include the provision of new information that may result in DHS changing its decision.

(2) A written request for Agreement pre-termination hearing must be received by the Administrator of AMH within ten (10) days of the date of the issuance of DHS notice of termination. If a written request for Agreement pre-termination hearing is not received within this ten (10) day period or if Contractor withdraws a hearing request, any right to such hearing shall be considered waived.

(3) Contractor must submit any documentation it intends to ask the Administrator of AMH to review at the Agreement pre-termination hearing. In the Administrator's discretion, the Agreement pre-termination hearing can occur based solely on document review. If the Administrator decides that a meeting will assist the decision, the Administrator will notify Contractor requesting the Agreement pre-termination hearing of the date, time and place of the meeting. The meeting will be conducted in the following manner:

(a) It will be conducted by the Administrator of AMH, or designee;

(b) No minutes or transcript of the meeting is required;

(c) Contractor will be given an opportunity to present information.

(d) DHS staff will not be available for cross-examination, although staff may assist the Administrator of AMH in providing information relevant to the hearing.

(e) The Administrator of AMH may request Contractor to submit documentation of new information that has been presented orally. In such an instance, a specific date for receiving such information will be established.

(f) The record of the hearing will include the information in DHS's file, and relevant information timely submitted to the Administrator of AMH by Contractor.

(g) The Administrator or designee shall issue an Agreement pre-termination hearing decision within thirty (30) days of the close of record.

(4) If Contractor timely requests an Agreement pre-termination hearing, the Administrator of AMH shall:

(a) Notify individuals enrolled with Contractor of the hearing request, and

(b) Permit such Enrollees to disenroll immediately with Contractor without cause.

(5) Where Contractor and DHS mutually agree to termination under Subsection a, Paragraph (1), above, or Contractor seeks to terminate this Agreement, Contractor will be deemed to have waived a request for pre-termination hearing.

d. Any termination of this Agreement shall be without prejudice to any obligations or liabilities of either party already accrued prior to such termination, except that Contractor shall be solely responsible for its obligations or liabilities after the termination date when the obligations or liabilities result from Contractor's failure to provide for termination of, or right to terminate, its commitments concurrently with and consistent with the termination of this Agreement.

e. In the event of termination of this Agreement, DHS will give OHP Members notice of the termination and information on options for receiving Covered Services following the date of termination.

(1) Contractor shall ensure the orderly and reasonable transfer of OHP Member care in progress, whether or not those OHP Members are hospitalized.

(2) If Contractor chooses to Provide Services to a former OHP Member who is no longer an OHP Member or who is enrolled with another contractor at the time Contractor renders the Service, DHS shall have no responsibility to pay for such Services.

(3) Upon termination, DHS shall conduct a final accounting of Capitation Payments received for OHP Members enrolled during the month in which termination is effective and shall be accomplished as follows:

(a) Mid-month Termination: For termination of this Agreement 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 DHS shall be entitled to a refund for the balance of the month.

(b) Responsibility for Claims: Contractor is responsible for any and all claims from Subcontractors or other Providers, including Emergency Service Providers, for Covered Services provided prior to termination date. Contractor shall promptly notify DHS of any outstanding claims for which DHS may owe, or be liable for, a Fee-For-Service payment, which are known to Contractor at the time of termination or when such new claims incurred prior to termination are received. Contractor shall supply DHS, with all information necessary for reimbursement of such claims.

(4) The rights and obligations of the parties arising under the following: Exhibit B, Part V, Section 1, Recordkeeping, Subsection c, Government Access to Records; Exhibit D, Section 1, Controlling State Law/Venue; Exhibit D, Section 10, Terminations, Subsection c and Subsection d; Exhibit F, Insurance Requirements, shall survive the termination or expiration of this Agreement.

AMH intends to amend this Agreement pursuant to Exhibit D, Section 18, to reflect implementation of its new Medical Management Information System (MMIS).

11. Limitation of Liabilities.

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.

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 Agreement in order to make audits, examinations, excerpts, transcripts and copies of such documents to:

(1) AMH;

(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., above, Contractor and its agents, employees and Subcontractors shall maintain all OHP 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, Record Keeping of this Agreement.

(1) For the protection of OHP 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 Agreement, except with the written consent or authorization of the OHP Member, his or her attorney, or, the OHP Member Representative, or except as permitted by ORS 179.505 or by 2007 Senate Bill 163 (Chapter 798, 2007 Laws) 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 OHP 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 OHP 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 OHP 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 Department is subject to the Public Records Law, ORS 192.410 et. seq.

14. Force Majeure

Neither Contractor nor DHS shall be held responsible for delay or default caused by fire, riot, war, major disaster, epidemic, or acts of God which is beyond either Contractor's or DHS's reasonable control. Contractor or DHS shall, however, make all reasonable efforts to remove or eliminate such a cause of delay or default and shall, upon cessation of the cause, diligently pursue performance obligations under this Agreement.

If the rendering of Services or benefits under this Agreement is delayed or made impractical due to a labor dispute involving Contractor, care may be deferred until after resolution of the labor dispute except when care or Service is needed for an emergency or Urgent need or when there is a potential for a serious adverse mental health or medical consequence if Treatment or Diagnosis is delayed more than thirty (30) calendar days.

If a labor dispute disrupts normal execution of Contractor duties under this Agreement, Contractor shall notify OHP Members in writing of the situation and direct OHP 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 Agreement without the prior written consent of AMH. Subject to the immediately preceding sentence, the provisions of this Agreement 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 Agreement, all of the following fundamental changes shall be considered an assignment of an interest in this Agreement subject to AMH 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 AMH at least forty-five (45) calendar days prior to any assignment or transfer of an interest in this Agreement 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 is responsible for the Quality of Care and Services provided under the terms and requirements of this Agreement. Subject to the provisions of this section, Contractor may subcontract any or all of the work to be performed under this Agreement. No subcontract shall terminate or limit Contractor's legal responsibility to DHS for the timely and effective performance of its duties and responsibilities under this Agreement.

a. Before any delegation of activities, Contractor shall evaluate the prospective Subcontractor's ability to perform the activities to be delegated.

b. Contractor shall have a written agreement that specifies the delegated activities and reporting responsibilities of the Subcontractor.

c. The following requirements of this Agreement may not be delegated:

(1) Oversight and Monitoring of QA/PI Activities;

(2) Adjudication of Final Appeals in a Member Grievance and Appeal Process; and

d. Contractor's agreement with the Subcontractor shall provide for the revocation of the delegation or imposition of other sanctions if the Subcontractor's performance is inadequate to meet the requirements of this Agreement.

e. Contractor shall monitor the Subcontractor's performance on an ongoing basis and perform a formal review of compliance with delegated responsibilities at least once a year. Upon identification of areas for improvement or deficiencies, Contractor and Subcontractor must take corrective action.

f. All subcontracts shall meet the requirements described below and shall incorporate portions of this Agreement, as applicable, based on the scope of work to be subcontracted.

(1) Must be in writing and incorporate each applicable requirement of this Agreement, including the following: Exhibit B, Part V, Section 1, Recordkeeping; Exhibit D, Section 7, Indemnification; Section 10, Termination, Section 18, Amendments and Section 25, Tort Claims; Exhibit E, Required Federal Terms and Conditions; Exhibit F, Insurance Requirements; and every other provision in this Agreement that sets requirements for any of the activities being subcontracted.

(2) Clearly identify work to be performed by the Subcontractor and what portion of that work, if any, the Subcontractor may further subcontract.

(3) Ensure that the requirements of 42 CFR Part 438 that are appropriate to the Services or activity required under the subcontract are fulfilled.

(4) Contain a provision that the Subcontractor and referral Providers shall not bill, charge, seek compensation, remuneration or reimbursement from, or have recourse against DHS or any OHP Member for Covered Services provided during the period for which Capitation Payments were made by DHS to Contractor with respect to said OHP Member, even if Contractor becomes insolvent. Subcontractors and referral Providers

may not bill OHP Members any amount greater than would be owed by the OHP 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 follow OAR 410-141-0420, Billing and Payment Under the Oregon Health Plan, when submitting Fee-For-Service claims for Oregon Health Plan Services provided to OHP Members that are not Covered Services.

(7) In cases where the Subcontractor has assumed any risk covered under this Agreement, 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.

(8) If Contractor chooses to delegate the Grievance and Appeal Process, Contractor shall require the Subcontractor to have written policies and procedures for accepting, processing and responding to all Grievances from Family Members, Local and/or Regional Allied Agencies, and OHP Members consistent with Exhibit N, MHO Grievance System.

(9) Contain a provision that data used for analysis of delivery system Capacity, Consumer satisfaction, financial solvency, and Encounter, client process monitoring, and Acute Inpatient Hospital Psychiatric Care admission data submission must be provided to Contractor to meet reporting requirements described in Exhibit K, Mental Health Services Practitioner Report; Exhibit L, Mental Health Organization (MHO) Grievance Log; Exhibit G, Solvency Plan and Financial Reporting; Exhibit H, Encounter Minimum Data Set Requirements; Schedule 1, Client Process Monitoring System; and Schedule 3, Oregon Patient/Resident Care System.

(10) Contain a provision that requires the Subcontractor to have a planned, systematic and ongoing process for monitoring, evaluating and improving the quality and Appropriateness of Covered Services provided to OHP Members.

(11) Contain a provision that requires the Subcontractor to participate in QA and QI activities of Contractor, or those of AMH if requested to do so.

(12) 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 Recordkeeping, Exhibit B, Part V, Section 1, Recordkeeping and Exhibit B, Part VI, Section 1, AMH Compliance Review and Quality Assurance Monitoring and to cooperate with AMH in medical and financial record reviews, and Agreement compliance and QA monitoring.

(13) Contain a provision that requires the Subcontractor to cooperate with all processes and procedures of Abuse reporting, investigations, and protective Services as described in ORS 430.735 through 430.765, Abuse Reporting for Mentally Ill and OAR 410-009-0050 through 410-009-0160, Abuse Reporting and Protective Services in Community Programs and Community Facilities.

(14) If Contractor chooses to delegate Utilization Management activities, Contractor shall assure that compensation to Providers is not structured so as to provide incentives to deny, limit or discontinue Medically Appropriate services to OHP members.

g. On the effective date of this Agreement, Contractor shall notify AMH in writing of activities to be delegated and the entities performing such delegated activities. Contractor shall provide a list which shall include the delegated entity's business name, address, phone number, name of executive director and activities to be performed. Contractor shall notify AMH in writing of changes to the list within thirty (30) calendar days of such change.

17. No Third Party Beneficiaries

DHS and Contractor are the only parties to this Agreement and are the only parties entitled to enforce its terms. Nothing in this Agreement 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 Agreement.

18. Amendments

The terms of this Agreement shall not be waived, altered, modified, supplemented, or amended, in any manner whatsoever, without a duly executed amendment. Any amendments to this Agreement shall be effective only when reduced to writing, signed by both parties, and when signed by the Oregon Department of Justice as approved for legal sufficiency.

19. Severability

If any term or provision of this Agreement 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 the Agreement 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 Agreement shall not constitute a waiver of that or any other provision.

21. Notices

Any notice under this Agreement shall be deemed received the earlier of either the date of actual delivery or two (2) working days after mailing certified and postage prepaid through the U.S. Postal Service addressed as follows:

If to Contractor: To the address listed in Part VI,. Contractor Information, of this Agreement

If to an OHP Member: To the latest address provided for the OHP Member on an address list, Enrollment or change of address form actually received by Contractor.

If to DHS: AMH Medicaid Policy Unit Manager, 500 Summer St. NE, E-86, Salem, Oregon 97301-1118.

22. Construction

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

23. Headings and Captions

The headings used in this Agreement 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 Agreement.

24. Merger

This Agreement constitutes the entire agreement between the parties. No waiver, consent, modification or change of terms of this Agreement shall bind either party unless in writing and signed by both parties. 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 Agreement. Contractor, by signature of its authorized representative, hereby acknowledges that he or she had read this Agreement, 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 Agreement as independent Contractors and not as officers, employees, or agents of the State as those terms are used in ORS 30.265. It is understood, however, that if Contractor subcontracts with an Oregon public entity, officer or employee, that entity, officer or employee will be an independent Contractor but may be subject to the Oregon Tort Claims Act, ORS 30.260 to 30.300.

26. Counterparts

This Agreement 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 Agreement 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 Agreement, to Contractor, or to the Work, or to any combination of the foregoing. For purposes of this Agreement, 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 Agreement 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 Agreement: (a) Title VI and VII of the Civil Rights Act of 1964, (b) 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, (h) 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 Agreement 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, Prevention and Detection of 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 Agreement.

3. Equal Employment Opportunity

If this Agreement, 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 Agreement, 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, HHS 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.

This certification is a material representation of fact upon which reliance was placed when this Agreement was made or entered into. Submission of this certification is a prerequisite for making or entering into this Agreement 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. Health Insurance Portability and Accountability Act (HIPAA)

a. Contractor is a "covered entity" for the purposes of the provisions of the Health Insurance Portability and Accountability Act (HIPAA), Title II, Subtitle F, Administrative Simplification, or the federal regulations implementing the Act. 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 consistent with HIPAA and/or other federal, state, and local laws, rules and regulations applicable to the work performed under this Agreement.

b. Contractor, its agents, employees, Providers and Subcontractors shall ensure that confidential records are secure from unauthorized disclosure. Electronic storage and transmission of confidential OHP Member information and records shall assure accuracy, backup for retention, and safeguards against tampering, back dating, or alteration.

c. Guidelines to ensure the security of the electronic transmission of OHP Member confidential information shall be developed by DHS. Within the available resources, and consistent with DHS's testing schedule, Contractor shall initiate a request to DHS for testing and review of security measures.

d. Contractor shall comply with HIPAA standards for electronic transactions published in 65 Fed. Reg. 50312 (August 17, 2000) and consistent with the Administrative Simplification Compliance Act (extending the deadline for compliance with transaction and code set requirements until October 12, 2003, subject to submission of a compliance plan to DHHS). Contractor shall initiate a request to DHS for the testing of systems and the implementation of such policies and procedures as may be required to comply with HIPAA standards.

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, Suspension and Terminated Providers

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.

The Covered Services provided by Contractor under this Agreement may not be rendered by individuals or entities who are currently excluded from Medicaid participation under Section 1128 or Section 1128A of the Social Security Act. Contractor shall not refer OHP Members to such Providers and shall not accept billings for Services to OHP Members submitted by such Providers.

11. Drug-Free Workplace

Contractor shall comply and cause all Subcontractors to comply with the following provisions to maintain a drug-free workplace: (i) 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; (ii) 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; (iii) Provide each employee to be engaged in the performance of services under this Agreement a copy of the statement mentioned in Paragraph 10(i) above; (iv) Notify each employee in the statement required by Paragraph 10(i) that, as a condition of employment to Provide Services under this Agreement, 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; (v) Notify DHS within ten (10) days after receiving notice under subparagraph 10(iv) from an employee or otherwise receiving actual notice of such conviction; (vi) 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; (vii) Make a good-faith effort to continue a drug-free workplace through implementation of subparagraphs 10(i) through 10(vi); (viii) Require any Subcontractor to comply with subparagraphs 10(i) through 10(vii); 10(ix) Neither Contractor, or any of Contractor's employees, officers, agents or Subcontractors may Provide any Service required under this Agreement 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; (x) Violation of any provision of this subsection may result in termination of this Agreement.

12. Pro-Children Act

Contractor shall comply and cause all Subcontractors 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 and any laboratories used by Contractor shall comply with the Clinical Laboratory Improvement Amendments (CLIA 1988) which require that:

All laboratory testing sites providing Services under this Agreement shall have either a Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver or a certificate of registration along with 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 the requirements of 42 CFR Part 489, Subpart I Omnibus Budget Reconciliation Act (OBRA) 1990, Patient Self Determination Act and ORS Chapter 127, pertaining to advance directives.

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

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 an OHP Member. Contractor shall comply with all requirements of Exhibit M, Practitioner Incentive Plans, 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 Agreement 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 its Subcontractors 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 Agreement.

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 Law 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).

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. Federal Grant Requirements

The federal Medicaid rules establish that the Department 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 Department requires Contractor to supply information or comply with procedures to permit the Department 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 Agreement for roads, bridges, stadiums, or any other item or service not covered under the Oregon Health Plan.

22. Provider's Opinion

OHP 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 Oregon Health Plan.

Contractor shall not prohibit or otherwise restrict a Health Care Professional from advising an OHP Member who is a patient of that professional about the health status of the OHP Member or treatment for the OHP 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

1. Public Contractor's Liability

If Contractor is a county (as the word "county" is used in Article XI, Section 10 of the Oregon Constitution), notwithstanding any other provisions of this Agreement, including without limitations the following sections of Exhibit B, Part III, Section 4, Enrollment and Disenrollment and Exhibit C, Section 5, Settlement of Accounts and Exhibit B, Part VI, Section 2, Remedies Short of Termination, of this Agreement, Contractor's liability under this Agreement is subject to the limitations of Article XI, Section 10 of the Oregon Constitution. However, Contractor shall exercise its best efforts in maintaining adequate reserves (including, if necessary, reserves in excess of the amount specified in Exhibit G, Solvency Plan and Financial Reporting), obtaining appropriate loss and liability insurance and seeking any necessary funding or spending authorization so as to prevent its responsibilities under this Agreement from becoming a debt or a pledge of credit in violation of the provisions of Article XI, Section 10 of the Oregon Constitution. In the event that Contractor anticipates or determines that its responsibilities under this Agreement might or will violate Article XI, Section 10 of the Oregon Constitution, Contractor shall immediately notify DHS, and DHS may, in its sole discretion, terminate this Agreement upon notice to Contractor or at some later date specified in the notice.

2. Professional Liability Insurance

Contractor shall ensure that all persons and entities performing Services under this Agreement obtain and keep in effect during the term of this Agreement professional liability insurance which provides coverage of direct and vicarious liability relating to any damages caused by an error, omission or any negligent acts. Except to the extent that the Oregon Tort Claims Act, ORS 30.260 or 30.300, is applicable and imposes lesser limitations, Contractor shall ensure professional liability insurance coverage of not less than the amount of $1,000,000 per person per incident and not less than $1,000,000 in the aggregate either through a binder issued by an insurance carrier or by Contractor's self-insurance with proof of same to be provided to AMH upon request.

3. Workers' Compensation Coverage

All employers, including Contractor, that employ workers who work under this Agreement in the State of Oregon shall comply with ORS 656.017 and provide the required Workers' Compensation coverage, unless such employers are exempt under ORS 656.126. Contractor shall ensure that each of its Subcontractors complies with these requirements.

Exhibit G – Solvency Plan and Financial Reporting

Contractor shall maintain sound financial management procedures, maintain protections against Insolvency commensurate with the number of OHP Members and level of risk assumed, and generate periodic financial reports for submission to AMH (OAR 410-141-0340). Financial management, solvency protection, and reporting shall occur as specified below.

1. Contractor shall protect itself against catastrophic and unexpected expenses related to Covered Services by either self-insuring or by obtaining stop-loss protection from a private insurer in an amount sufficient to cover estimated risk for the duration of this Agreement. Contractor shall provide proof of such coverage to AMH within 30 days after the effective date of this Agreement.

2. Restricted Reserve Fund

Contractor shall maintain a Restricted Reserve Fund balance no less than $250,000 and provide evidence of the required restricted reserve account balance to AMH within 60 calendar days after the end of each calendar quarter as outlined below. Contractor shall identify where and by whom the restricted reserve account is held.

a. If Contractor subcontracts any work to be performed under this Agreement using a subcapitated reimbursement arrangement, Contractor may choose to require its Subcontractor to maintain a Restricted Reserve Fund for the Subcontractor's portion of the risk assumed or may maintain a Restricted Reserve Fund for all risk assumed under this Agreement. Regardless of the choice made, Contractor shall assure that the combined total Restricted Reserve Fund balance meets the requirements of this Agreement.

b. If the Restricted Reserve Fund is held in a combined account or pool with other entities, Contractor, and its Subcontractors as applicable, shall provide a statement from the pool or account manager that the Restricted Reserve Fund is available to Contractor, or its Subcontractors as applicable, and has not been obligated elsewhere.

c. If Contractor must use its Restricted Reserve Fund to finance Covered Services, Contractor shall provide advance written notice to AMH of the amount to be withdrawn, the reason for withdrawal, when and how the Restricted Reserve Fund will be replenished, and steps to be taken to avoid the need for future Restricted Reserve Fund withdrawals.

d. Contractor shall provide AMH access to its Restricted Reserve Fund if Insolvency occurs.

e. Contractor shall have written policies and procedures to ensure that, if Insolvency occurs, OHP Members and related Clinical Records are transitioned with minimal disruption.

3. Contractor shall provide Third Party Resource collection information, using Report G.2, Current OHP Members with Third Party Resources (Quarterly Report), on a quarterly basis within 60 calendar days after the end of each calendar quarter. Contractor shall make reasonable efforts to identify and pursue such Third Party Resource without regard to any Capitation Payments. Contractor shall keep records of such efforts, successful or unsuccessful, to ensure accuracy of such reports and make records available for audit and review upon request.

4. Contractor shall provide financial information, using Report G.3, Quarterly Balance Sheet, within 60 calendar days after the end of each calendar quarter. Contractor shall have systems that capture, compile, and evaluate information and data concerning financial operations including, but not limited to, the determination of future budget requirements and for determining, managing and accounting for "Incurred But Not Reported" expenses.

5. Contractor shall provide financial information, using Reports G.4, MHO Contractor's Quarterly Statement of Revenue and Expenses, G.4A, Health Care Expenses By Service Type, and C4B, Prevention/Education/Outreach Activities, on a quarterly basis within 60 calendar days after the end of each calendar quarter.

   In addition to the quarterly reports, Contractor shall provide a Report G.4 based on a fiscal year which shall include a detailed description of how a net loss was covered or how a net income will be used during the next fiscal year.

6. Contractor shall provide financial information, using Report G.5, Fiscal Year Cash Flow Analysis for Corporate Activity within 90 calendar days after the end of Contractor's fiscal year.

7. Contractor shall submit an Annual Audited Financial Statement to AMH within 180 days after the end of the Contractor fiscal year. The audited financial statement shall be prepared by an independent accounting firm. In conducting the audit of the financial statements, the auditor will apply sufficient procedures to conclude that, in all material respects:

   a. the assumptions and methods used in determining loss reserves, actuarial liabilities, or other related accounting items are appropriate in the circumstances, and

   b. the information on the Contractor's G.3, G.4, G.4A, G.4B and G.5 reports is accurately included within the amounts presented in the Contractor's financial statements and footnote disclosures.

8. Contractor shall notify AMH of any significant change to the information provided in the quarterly financial reports. If the change requires restatement of a prior quarterly financial report, Contractor shall amend the report and submit to AMH within 30 working days of the date the change is identified.

9. Contractor shall supply AMH with a spreadsheet, or other mutually agreed upon format, containing the quarterly financial reports either electronically or by mailing a 3.5" computer disk, CD, spreadsheet, hard copy or facsimile. Contractor shall send these reports to AMH, Medicaid Policy Unit, 500 Summer St. NE, Salem, Oregon 97301-1118.

10. If Contractor has questions about these reports, Contractor may call the AMH, Medicaid Policy Unit, OHP Mental Health Specialist at (503) 947-5530.

11. If Contractor wants these reports electronically, on a 3.5" computer disk, CD, spreadsheet, hard copy or facsimile, Contractor may call (503) 947-5530.

Exhibit G – Attachment 1
Report G.2: Current OHP Members with Third Party Resources (Quarterly Report)

MHO:_____

Report Period: _____

Report Period: □ 1st Quarter (Jan-Mar) □ 2nd Quarter (Apr-Jun)
□ 3rd Quarter (Jul-Sep) □ 4th Quarter (Oct-Dec)

Report due within 60 calendar days after the end of each calendar quarter.

Instructions:.

1. Provide Third Party Resource information for Covered Services.

2. Separate amounts collected by Medicare, other insurance collections, and tort and estate collections, and Capitation rate category.

3. If the accounts receivable system cannot capture collections by Capitation rate category, do the following:

   a. Record total collections by Medicare, other insurance, and tort and estate recoveries.

   b. Keep detailed records of all collections by OHP Member name, prime number and Third Party Resource.

   c. Provide a written statement with the report indicating when Third Party Resource collection information will be available by Capitation rate category.

Capitation Rate Category	Medicare Collections	Other Insurance Collections	Tort and Estate Collections
1. TANF			
2. General Assistance			
3. PLM Adults under 100% FPL			
4. PLM Adults over 100% FPL			
5. SCHIP Children Aged 0 - 1			
6. PLM Children Aged 0 - 1			
7. PLM or SCHIP Children Aged 1- 5			
8. PLM or SCHIP Children Aged 6 - 18			

Capitation Rate Category		Medicare Collections	Other Insurance Collections	Tort and Estate Collections
9.	OHP Families			
10.	OHP Adults & Couples			
11.	AB/AD with Medicare			
12.	AB/AD without Medicare			
13.	OAA with Medicare			
14.	OAA with Medicare Part B Only			
15.	OAA without Medicare			
16.	CAF Children			
17.	Total Collections			

Revised, January 1, 2008

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Preparer's signature and phone number

Exhibit G – Attachment 2
Report G.3: Quarterly Balance Sheet

MHO:_____

Report Period: □ 1st Quarter (Jan-Mar) □ 2nd Quarter (Apr-Jun)
□ 3rd Quarter (Jul-Sep) □ 4th Quarter (Oct-Dec)

Report due within 60 calendar days after the end of each calendar quarter.

Category		MHO Activities Under this Agreement
CURRENT ASSETS		
1.	Cash and Cash Equivalents	
2.	Short-Term Investments	
3.	Investment Income Receivables	
4.	Health Care Receivables	
5.	Prepaid Expenses	
6.	Other Current Assets	
7.	**Total Current Assets**	
OTHER ASSETS		
8.	Restricted Cash and Restricted Securities	
9.	Other Long-Term Investments	
10.	Other Assets (Please specify)	
	(a)	
	(b)	
	(c)	
11.	**Total Other Assets**	
PROPERTY AND EQUIPMENT		
12.	Land, Buildings and Improvements	
13.	Furniture and Equipment	
14.	Leasehold Improvements	
15.	Other Property and Equipment	
16.	**Total Property and Equipment**	
17.	**TOTAL ASSETS**	

Category	MHO Activities Under this Agreement
CURRENT LIABILITIES	
18. Accounts Payable	
19. Claims Payable	
20. Incurred but Not Reported	
21. Accrued Medical Incentive Pool	
22. Loans and Notes Payable	
23. Other Current Liabilities	
24. Stop Loss Insurance	
25. **Total Current Liabilities**	
OTHER LIABILITIES	
26. Loans and Notes Payable	
27. Other Liabilities	
28. **Total Other Liabilities**	
29. **TOTAL LIABILITIES**	
NET WORTH	
30. Contributed Capital	
31. Contingency Reserves	
32. Retained Earnings/Fund Balance	
33. Other Net Worth	
34. **Total Net Worth**	
35. **TOTAL LIABILITIES AND NET WORTH**	

Revised, January 1, 2008

Notes:

_____

Preparer's signature and phone number

Report G.3 – Quarterly Balance Sheet

Definitions for this report:

Balance Sheet: A financial statement that has been developed using generally accepted accounting principles and that shows the financial position of a business on a particular date.

If separate accounts are not kept for Covered Services, balance sheet information for such Covered Services may be allocated using an estimation procedure. Such procedure and all assumptions must be disclosed in Notes. This estimation procedure must be used throughout the report.

1. **Cash and Cash Equivalents:** Cash in the bank or on hand, available for current use. Cash equivalents are investments maturing 90 calendar days or less from date of purchase.

2. **Short-Term Investments:** Principal amounts of investments in securities that are readily marketable, maturing one year or less from date of purchase.

3. **Investment Income Receivables:** Income, including interest accrued or dividends earned on short term or long term investments.

4. **Health Care Receivables:** Includes FFS, coordination of benefits, subrogation, copayments, Reinsurance recoveries and non-affiliated provider receivables.

5. **Prepaid Expenses:** Any expenses paid and recorded in advance of its use or consumption in the business, which properly represents a portion as an expense of the current period and a portion as an asset on hand at the end of the period.

6. **Other Current Assets:** Other assets not included in the asset categories listed above, including any other accounts receivable.

7. **Total Current Assets:** The sum of lines 1 through 6.

8. **Restricted Cash and Restricted Securities:** Assets restricted for statutory Insolvency requirements held for contract.

9. **Other Long-Term Investments:** Principal amounts of investments with a maturity longer than one year from date of purchase or no stated maturity date.

10. **Other Assets:** Other assets, such as aggregate write-ins, bonds, preferred stocks, receivables from securities, etc. (Please specify)

11. **Total Other Assets:** The sum of lines 8 through line 10.

12. **Land, Buildings and Improvements:** Net book value of land and buildings owned by Contractor, and any improvements made to buildings, or improvements in progress.

13. **Furniture and Equipment:** Net book value of office equipment, including computer hardware and software (where permitted), and furniture owned by Contractor.

14. **Leasehold Improvements:** Net book value of improvements to facilities not owned by Contractor. Provide net amount (gross amount less amortization).

15. **Other Property and Equipment:** Net book value of other tangibles and, fixed assets that are not included on Lines 12, 13, and 14.

16. **Total Property and Equipment:** The sum of lines 12 through line 15.

17. **Total Assets:** The sum of lines 7, 11 and 16.

18. **Accounts Payable:** Amounts due to creditors for the acquisition of goods and services (trade and vendors rather than health care practitioners) on a credit basis.

19. **Claims Payable:** Claims reported and booked as payables claims (minus incentives and stop loss).

20. **Incurred But Not Reported (IBNR):** 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.

21. **Accrued Medical Incentive Pool:** Liability for arrangements whereby Contractor agrees to share Utilization savings with Individual Practice Associations, physician groups, or other providers.

22. **Loans and Notes Payable:** The principal amount on loans or notes due within one year.

23. **Other Current Liabilities:** Any payable amount other than direct health care services to affiliates and any liabilities not included in the current liabilities categories listed above.

24. **Stop Loss Insurance:** Protection against catastrophic and unexpected expenses related to Capitated Services. The method of protection may include the purchase of Stop Loss Coverage, Reinsurance, self insurance or any other alternative determined acceptable by AMH.

25. **Total Current Liabilities:** The sum of lines 18 through 24.

26. **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).

27. **Other Liabilities:** Other liabilities not included in the liabilities categories listed above.

28. **Total Other Liabilities:** The sum of lines 26 and 27.

29. **Total Liabilities:** The sum of lines 25 and 28.

30. **Contributed Capital:** Capital donated to Contractor.

31. **Contingency Reserves:** Reserves held for contingency purposes as defined in state statutes and regulations.

32. **Retained Earnings/Fund Balance:** The undistributed and unappropriated amount of surplus.

33. **Other Net Worth:** Other net worth items not reported on any other lines.

34. **Total Net Worth:** The sum of line 30 through 33.

35. **Total Liabilities and Net Worth:** The sum of lines 29 and 34.

Exhibit G – Attachment 3
Report G.4: MHO Contractor's Quarterly Statement of Revenue and Expenses

MHO: _____

Subcontractor: _____

Report Period: ☐ 1st Quarter (Jan-Mar) ☐ 2nd Quarter (Apr-Jun)
☐ 3rd Quarter (Jul-Sep) ☐ 4th Quarter (Oct-Dec)
☐ Fiscal Year

Report due within 60 calendar days after the end of each quarter to be submitted for both Contractor and risk based Subcontractors.

☐ **Full Accrual** ☐ **Modified Accrual** ☐ **Cash (Please Specify)**

Category		OHP Activity under this Agreement
REVENUES		
1.	Capitation	
2.	Other Health Care Revenues (please specify)	
	(a)	
	(b)	
	(c)	
3.	**Total Revenues**	
HEALTH CARE EXPENSES		
4.	Health Care Expenses	
	(a) Staff Model	
	(b) Fee-for-Service	
	(c) Risk Models	
	(d) Other payment arrangements	
5.	Incentive Pool and Withhold Adjustments	
6.	Subcapitation Payments	
7.	Other health care expenses not included above. (please specify)	
8.	**DEDUCTIONS**	
	(a) Coordination of Benefits	
	(b) Reinsurance Recoveries Incurred	
	(c) Subrogation	
9.	**TOTAL HEALTH CARE EXPENSES**	

Category		OHP Activity under this Agreement
ADMINISTRATIVE EXPENSES		
10.	Contractor	
11.	Subcontractor	
12.	MCO Provider Tax	
13.	Total Adminstrative Expenses	
14.	**TOTAL EXPENSES**	
15.	**NET INCOME (LOSS)** [1]	
16.	Beginning Balance	
17.	Increase (Decrease) in Retained Earnings/Fund Balance	
18.	Other Changes	
19.	Balance at End of Period	

Accounting of Net Income (Loss) Recorded on Line 15:

Contractor shall submit a detailed description of how a net loss was covered or how a net income will be used during the next fiscal year.

The fiscal year G.4 report shall include a detailed description of how a net loss was covered or how a net income will be used. This shall include the amount to be retained, the amount to be reinvested, the timeline of reinvestment and a narrative describing how the reinvestment will benefit the OHP Members and/or support mental health stakeholders.

Line 15 Amount $_____

Revised, January 1, 2008

_____

Preparer's signature and phone number

[1] Complete accounting of net income (loss) recorded on line 15.

Report G.4 – MHO Contractor's Quarterly Statement of Revenue and Expenses

Definitions for this report:

Statement of Revenue and Expenses: A financial statement reporting fully accrued revenues and expenses under this Agreement for the period. Contractor shall indicate the accounting method used for this report: Full accrual, modified accrual, or cash basis. Expenses should be appropriately reported for health care and administrative expenses.

When a Contractor reports an expense on Report G.4 Line 6 "Subcapitation payments", the Contractor shall have Subcontractors receiving subcapitation funds complete Reports G.4, G.4A, and G.4B. Contractor shall attach Subcontractor's Reports G.4, G.4A, and G.4B with Contractor's quarterly statements when submitting them to AMH.

OHP Activity: The financial position of Contractor relating to activities that are associated with Covered Services provided under the Oregon Health Plan (OHP) under this Agreement.

Allocation of expenditures between OHP and other line of business. If separate accounts are not kept for the OHP, revenue and expenses for the OHP may be allocated using an estimation procedure. Such a procedure and all assumptions must be disclosed in Notes to Report G.4. This estimation procedure must be used throughout the reports. The assumptions underlying the allocation must be based on a methodology that clearly represents the costs associated with providing Covered Services to OHP Members.

Contractor shall indicate the beginning balance for the reporting period.

Revenues

1. **Capitation:** The amount received by Contractor on a per member per month basis in advance of and as payment for the provision of Covered Services to OHP Members enrolled with Contractor over a defined period of time.

2. **Other Health Care Revenues:** Other revenues recognized as a result of other non-capitated arrangements between Contractor and AMH for Covered Services provided under this Agreement for OHP Members not included in the previous revenue categories. Please specify.

3. **Total Revenues:** The sum of lines 1 and 2.

Health Care Expenses: These are the costs that can be identified specifically with activities associated with providing services to OHP Members. Examples of health care costs are compensation of employees for the time devoted to activities associated with providing Covered Services to OHP Members, the cost of material acquired, consumed, or expended specifically for the purpose of such activities, equipment and capital expenditures specifically identified with such activities, and travel expenses incurred specifically to carry out such activities.

4. **Health Care Expenses:**

   a. **Staff Model:** Amounts paid by Contractor for the provision of Covered Services to enrolled OHP Members. Include salaries, fringe benefits, other compensations to staff engaged in the delivery of Covered Services and to personnel engaged in activities in direct support of the provision of Covered Services and other expenses as defined in health care expenses above. Exclude expenses for personnel time devoted to administrative tasks.

   b. **Fee for Service:** Amounts paid for the provision of Covered Services dependent on the actual number and nature of services provided to each OHP Member.

   c. **Risk Models:** Amounts paid where the Provider receives a fixed amount and assumes financial liability for the provision of Covered Services for OHP Members, such as DRGs or case rates.

   d. **Other Payment Arrangements:** Amounts paid under other Service payment arrangements not included in above categories.

5. **Incentive Pool and Withhold Adjustments:** Adjustments made to expenses that reflect the incentive pool and withhold activities.

6. **Subcapitation Payments:** Amounts paid by Contractor to a Provider in advance of and as payment for actual receipt of Covered Services, either on a per-member-per-month basis, or on the basis of a formula for allocation whereby the Provider assumes risk for the provision of all Medically Appropriate Covered Services to OHP Members who are enrolled with that Provider during the month.

7. **Other health care expenses not included above. (please specify)**

8. **Deductions:**

   a. Coordination of Benefits: Income earned from Medicare, third party resources, and other insurance collections.

   b. Reinsurance Recoveries Incurred: Amounts received from the reinsurer on paid losses and those amounts that have been billed to the reinsurer and not yet received.

   c. Subrogation: Amounts received from other insurance recoveries, tort and estate collections.

9. **Subtotal Health Care Expenses:** The sum of lines 5 through 7 minus line 8.

Administrative Expenses: Administrative costs are those associated with the overall management and operations of Contractor .

10. **Contractor**: All expenses by Contractor for administrative services such as claims and encounter processing, contract services, financial services, member services, provider relations, utilization management, and quality management.

11. **Subcontractor**: All expenses by Subcontractor for administrative services such as claims and encounter processing, contract services, financial services, member services, provider relations, utilization management, and quality management.

12. **MCO Provider Tax:** Payment made for managed care taxes.

13. **Total Administrative Expenses:** The sum of lines 10 and 11.

14. **Total Expenses:** The sum of lines 9 and 12.

15. **Net Income (Loss):** The result of line 3 and 13.

    If submitting this form as a fiscal year Report G.4 and the amount reflects a net loss, then Contractor must describe how such loss was covered during the reporting period. If this figure reflects a net income, then Contractor must describe how the net income will be used in the next fiscal year.

16. **Beginning Balance of Period:** The total contributed capital, surplus notes, retained earnings/fund balance, and other items at the beginning of the report period.

17. **Increase (Decrease) in Retained Earnings/Fund Balance:** Changes in retained earnings/fund balance from the last report period to the current report period.

18. **Other Changes:** Changes in other items from the last report period to the current report period.

19. **Balance at End of Period:** Contributed capital, retained earnings/fund balance and other items at the end of the report period.

Exhibit G – Attachment 4
Report G.4A: Health Care Expenses by Service Type

MHO: _____

Subcontractor: _____

Report Period: □ 1st Quarter (Jan-Mar) □ 2nd Quarter (Apr-Jun)
□ 3rd Quarter (Jul-Sep) □ 4th Quarter (Oct-Dec)
□ Fiscal Year

Report due at the same time as Report G.4 for both Contractor and risk based Subcontractors, within 60 calendar days after the end of each quarter.

Category	OHP Activity under this Agreement
Outpatient	
Sub Acute & Other 24 hour Services	
Inpatient	
Prevention, Education and Outreach [1]	
Treatment Support Services & Supplies	
Consumer Operated Services	
Other Non-Encountered Services	
TOTAL HEALTH CARE EXPENSES [2]	

Revised, January 1, 2008

_____
Preparer's signature and phone number

[1] When an expense is reported on Report G.4A Line 4, complete and attach Report G.4B-Prevention/Education/Outreach Activities

[2] Total of line 8 "TOTAL HEALTH CARE EXPENSES" on Report G.4A must equal line 9 "Total Health Care Expenses" on Report G.4.

Report G.4A – Health Care Expenses by Service Type

Definitions for this report:

Contractor: Complete and attach Report G.4A with its completed Report G.4. Include all completed Reports G.4, G.4A and G.4B submitted by its Subcontractors with its own Reports G.4, G.4A, and G.4B.

Subcontractor: Complete and attach Report G.4A with its completed Report G.4, then submit the completed G.4, G.4A and G.4B reports to the Contractor.

1. **Outpatient:** Expenses for covered health care services. Exclude expenses for personnel time devoted to administrative tasks.

2. **Sub Acute & Other 24 hour Services:** Expenses for services provided in lieu of hospitalization or as a step down from acute care hospitalization.

3. **Inpatient:** All inpatient hospital costs while confined to an Acute Inpatient Hospital Psychiatric Care Setting.

4. **Prevention, Education and Outreach:** Outreach, Education and Prevention to OHP Members, not otherwise reportable as a service Encounter, treatment support services and supplies, or Consumer operated services. This category does not include marketing activities, provider training, or development and distribution of member handbooks.

5. **Treatment Support Services & Supplies:** Items or direct services provided to individuals as alternatives to Traditional Services and Flexible Services that are not otherwise reported as CPT or HCPC codes.

6. **Consumer Operated Services:** Supportive services provided by one or more Consumers or a Consumer run agency to groups and Family members which cannot be captured as CPT or HCPC codes. (e.g., a drop in center, telephone warm line, support group, etc.)

7. **Other Non-Encountered Services:** Other health care expenses for services not reported in above categories

8. **Total Health Care Expenses:** The sum of lines 1 through 7. Total of line 8 "TOTAL HEALTH CARE EXPENSES" on Report G.4A must equal line 9 "Total Health Care Expenses" on Report G.4.

Exhibit G – Attachment 5
Report G.4B: Prevention/Education/Outreach Activities

MHO: _____

Subcontractor: _____

Report Period: □ 1st Quarter (Jan-Mar) □ 2nd Quarter (Apr-Jun)
□ 3rd Quarter (Jul-Sep) □ 4th Quarter (Oct-Dec)
□ Fiscal Year

Report due at the same time as Report G.4 and G.4A - within 60 calendar days after the end of each quarter, to be submitted for both Contractor and risk based Subcontractors.

1. Provide information on Prevention/Education/Outreach activities for OHP enrolled members.

2. Report only those activities that cannot be otherwise reported using HCPC or CPT codes.

No.	Activity	Number of Activities	Time [3]	Cost [4]	No. of Members (actual or estimate)
1	PEO 1	Public Information			
2	PEO 2	Community Education			
3	PEO 3	Parent/Family Education			
4	PEO 4	Alternative Activities			
5	PEO 5	Community Mobilization			
6	PEO 6	Life Skills Development			
7	PEO 7	Prevention Support Activities			
8	PEO 8	Community Based Outreach			
9	PEO 9	Services Integration			
10	OTHER				
11	TOTAL PEO EXPENSES				

Revised, January 1, 2008

3 Actual time spend with members, reported in 15 minute increments. Time does not apply for PEO1.
4 Cost allocation for activity to include preparation, travel, equipment, and level of staff person.

Report G.4B – Prevention/Education/Outreach Activities

Definitions for this report:

1. **PEO 1 Public Information:** Presentation of accurate targeted messages and promotional material on mental health and substance abuse issues, such as suicide and teen pregnancies, to increase awareness of behavioral health. May include information seminars, electronic and print media. (Time does not apply for this activity)

2. **PEO 2 Community Education:** Community educational sessions with clear goals and objectives designed for a specific group that promotes a change in attitude and behaviors that may lead to behavioral health problems. May be ongoing and sequential.

3. **PEO 3 Parent/Family Education:** Educational sessions aimed at parents and Family members. May be one time only or ongoing, sequential sessions or workshops with defined goals and objectives. May include early childhood development, parenting skills, parent/child communication, and health families.

4. **PEO 4 Alternative Activities:** Alternative activities that provide challenging positive growth experiences, leading to the development of self-reliance and independence. Programs offer healthy alternatives for leisure/free time within the community Setting, e.g., hiking club, ropes course.

5. **PEO 5 Community Mobilization:** Community mobilization activities to deal effectively with behavioral health issues within the community, such as developing partnerships with schools/businesses, developing neighborhood coalitions, or training and technical assistance to coalitions.

6. **PEO 6 Life Skills Development:** Life skills development activities that assist individuals in developing or improving critical life skills. Must be ongoing, sequential learning activities or sessions that focus on the development of skills in decision making, coping with stress, values awareness, problem solving, conflict resolution, resistance skills, and self esteem.

7. **PEO 7 Prevention Support Activities:** Activities that support individuals in daily living or coping skills, such as warm lines.

8. **PEO 8 Community Based Outreach:** Activities provided in community Settings that attempt to engage individuals who might not otherwise access or seek out Traditional Services, such as Outreach to homeless individuals.

9. **PEO 9 Services Integration:** Includes participation in multi-disciplinary teams and community meetings where services are being discussed for an OHP Member who is not currently in services with a mental health provider.

10. **OTHER:** Expenses for other Prevention, Education, Outreach activities not reported in above categories.

11. **TOTAL PEO EXPENSES:** The sum of lines 1 through 10. Total of line 11 "Total PEO Expenses" on report G.4B must equal line 4 report G.4.

Exhibit G – Attachment 6
Report G.5: Fiscal Year Cash Flow Analysis for Corporate Activity-indirect Method

MHO:_____

Report Period: _____through_____

Report is due within 90 calendar days after the end of Contractor's fiscal year.

Provide the cash flow information for Corporate Activity. Note that cash flow resulting from an increase in operating assets, a decrease in operating liabilities, and a payment out is a debit. Note that cash flows resulting in receipt of cash or proceeds are credits.

Cash Flows Provided by			**MHO Corporate Activity**
OPERATING ACTIVITIES		**1.** Net Income (loss)	
	Adjustment to reconcile net income (loss to net cash)	**2.** Depreciation and Amortization	
	(Increase)/Decrease in Operating Assets	**3.** Health Care Receivables	
		4. Other Operating Costs	
		5. Claims Payable	
	Increase (Decrease) in Operating Liabilities	**6.** Unearned Capitation Amounts	
		7. Accounts Payable	
		8. Accrued Incentive Pool	
		9. Other Operating Activities	
10. NET CASH PROVIDED (USED) FROM OPERATING ACTIVITIES			
INVESTING ACTIVITIES	**11.** Receipts from Investments		
	12. Receipts for Sales of Property and Equipment		
	13. Payments for Investments		
	14. Payments for Property and Equipment		
	15. Other Increase (Decrease) in Cash Flow for Investing Activities		
16. NET CASH PROVIDED BY INVESTING ACTIVITIES			
FINANCING ACTIVITIES	**17.** Proceeds from Paid in Capital or Issuance of Stock		

Cash Flows Provided by		MHO Corporate Activity
FINANCING ACTIVITIES cont.	**18.** Loan Proceeds	
	19. Principal Payments on Loans	
	20. Dividends Paid	
	21. Principal Payments under Lease Obligations	
	22. Other Cash Flow Provided by Financing Activities	
23.	**NET CASH PROVIDED by FINANCING ACTIVITIES**	
24.	**NET INCREASE/(DECREASE) in CASH and CASH EQUIVALENTS**	
25.	**CASH and CASH EQUIVALENTS at BEGINNING OF REPORT PERIOD**	
26.	**CASH and CASH EQUIVALENTS at END of REPORT PERIOD**	

Revised, January 1, 2008

_____

Preparer's signature and phone number)

Report G.5 – Fiscal Year Cash Flow Analysis for Corporate Activity Indirect Method

Definitions for this report:

Contractor shall provide a Cash Flow Analysis report based on the corporate fiscal year within 60 days after the end of that fiscal year.

MHO Corporate Activity: Total financial information of any relevant organization, partnership, or joint venture incorporated under or subject to the provisions of ORS Chapters 60, 65, 190 and 732.005. The Corporate Activity for each Contractor is defined in Part III of this Agreement.

Cash Flow Provided by Operating Activities: Financial report estimating cash generated or lost from operating activities.

1. **Net Income (Loss):** Report Corporate Activity on Report G.4, Line 14 for the current quarter.

2. **Depreciation and Amortization:** Depreciation on property and equipment, and amortization on land.

3. **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.

4. **Other 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.

5. **Claims Payable:** Report any cash flow generated or lost by changes in 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.

6. **Unearned Capitation Amounts:** Report any cash flow generated or lost by changes in unearned capitation. 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. **Accrued Incentive Pool:** Report any cash flow generated or lost by changes in accrued 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.

9. **Other 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.

10. **Net Cash Provided (used) from Operating Activities:** Sum of lines 1 through 9. 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.

Cash Flows Provided by Investing Activities: Financial report showing the cash generated or lost from different investing activities.

11. **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.3.

12. **Receipts for Sales of Property and Equipment:** Cash generated by the transfer of cash into property and equipment sales transactions reported in Report G.3. 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.

13. **Payments for Investments:** Cash lost by the transfer of cash into either short-term or long-term investment transactions reported in Report G.3. Include cash lost by transfer of cash into restricted cash reserves and other assets that relate to transactions reported in Report G.3.

14. **Payments for Property and Equipment:** Cash lost by the transfer of cash into property and equipment sales transactions reported in Report G.3. 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.

15. **Other Increase (Decrease) in Cash Flow for Investing Activities:** Report any other cash flow generated or lost by changes in investing activities.

16. **Net Cash Provided by Investing Activities:** Sum of lines 11 through 15.

Cash Flows Provided by Financing Activities: Financial report showing the cash generated or lost from different financing activities.

17. **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.

18. **Loan Proceeds:** Cash generated by the transfer of cash from loan proceeds transactions.

19. **Principal Payments of Loans:** Cash lost by the transfer of cash from loan proceeds transactions.

20. **Dividends Paid:** Cash lost by paying dividends reported in Report G.3.

21. **Principal Payments under Lease Obligations:** Cash lost by the transfer of cash from loan proceeds transactions from lease obligations. Include loans and notes payable transactions reported in Report G.3.

22. **Other Cash Flow Provided by Financing Activities:** Any cash flow generated or lost by the transfer of cash in a financial transaction.

23. **Net Cash Provided by Financing Activities:** Sum of lines 17 through 22.

24. **Net Increase/(Decrease) in Cash and Cash Equivalents:** The sum of lines 10, 16 and 22.

25. **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.5.

26. **Cash and Cash Equivalents at End of Reporting Period:** The sum of lines 23 and 24.

Exhibit H – Encounter Minimum Data Set Requirements

1. General Provisions:

a. Contractor shall submit accurate and complete Encounter data to DHS pursuant to this Exhibit H. Contractor shall ensure that the data received from Providers is accurate and complete by:

(1) Verifying the accuracy and timeliness of reported data,

(2) Screening the data for completeness, logic and consistency, and

(3) Collecting Service information in standardized formats to the extent feasible and appropriate.

Contractor shall use the most current DSM Multi-axial classification system, inclusive of a complete five Axis diagnosis, and an ICD coding system, reported to the highest level of specificity.

b. DHS shall process Encounter data through the Medicaid Management Information System (MMIS). DHS shall "pend" all Encounters that cannot be processed because of missing or erroneous data.

(1) DHS shall notify Contractor of the status of all Encounter claims processed. Notification of all Pended Encounter Claims shall be provided to the Contractor each week that an Encounter claim remains Pended.

(2) Contractor shall correct all pended Encounters, within the time period identified in 1.c.(3), below.

c. Timelines

(1) Contractor must submit Encounter claims at least once per calendar month. The Encounter claims must represent at least 50% of all claim types (professional and institutional) received and adjudicated by Contractor that month.

(2) Contractor shall submit all original and unduplicated Encounter data to DHS within 180 days of the date of service. Circumstances not subject to the 180 day time frame include 1) Member's failure to give provider necessary claim information, 2) third party liability coordination, and 3) delays associated with resolving out-of-area claims, (4) hardware/software modifications specific to the mechanisms for processing encounter data and (5) Issues identified by AMH regarding DHS' encounter data processing system that make it problematic for Contractor to submit data (AMH will notify Contractor of such identified problems). Contractor shall structure its subcontracts and Participating Provider reimbursement arrangements to ensure timely submission of billings.

(3) Contractor shall submit all corrections to pended Encounters to DHS within 63 calendar days of the date that DHS notifies Contractor that the Encounters were pended. Claims for correction that are not submitted within 63 days are subject to Corrective Action. (See Exhibit B, Part VI, Section 2 entitled "Remedies Short of Termination" of this Agreement.)

(4) Contractor shall submit Encounter data for Covered Services known to have been provided to OHP Members. Contractor shall submit such Encounters regardless of the reimbursement method used, claim payment status (the claim was denied), placement on the Prioritized List of Health Services, or Third Party Resource status.

d. Data Transmission and Format

(1) 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.

(2) Contractor shall submit all data in a format approved by DHS.

(3) Contractor may have another entity submit Encounter data on its behalf, however, Contractor shall request approval of such arrangement from the designated Encounter Data Unit, Operations Section, DMAP, DHS. Contractor shall remain responsible for Encounter data accuracy, timeliness and completeness regardless of the entity submitting the Encounter data.

2. Data Set Requirements

a. The data elements specified in this section constitute the required minimum data set. Contractor is required to submit all of the data specified in this section.

b. Contractor shall submit the following identifying information for all Encounters:

(1) Contractor's DHS Prepaid Health Plan Provider Number

(2) OHP Member Name

(3) Medicaid Recipient Number, also known as the OHP Prime Number

(4) Disposition of the claim (accepted/rejected)

(5) Disposition Reason valid Claim Adjustment Reason Code(s) (CARC) (Contractor's determination at the service line that a liability exists).

c. For outpatient mental health Encounters, in addition to the identifying information listed in Subsection 2.b., DHS requires a HIPAA 837 Professional Transaction (837P) Form and the following minimum data elements for DHS processing of Encounter data claims:

(1) NPI for a performing or rendering Provider

(a) Contractor shall use the NPI assigned, including any Provider Taxonomy Code, for the CMHP or AMH certified organization employing the Health Care Professional delivering Covered Services to the OHP Member. If Covered Services are rendered by Health Care Professionals not associated with a CMHP or AMH certified organization, Contractor shall also an NPI as required by 45 CFR 162.410 for submissions.

(b) The use of default Provider numbers are not acceptable as a Provider number. Only an NPI and a Provider Taxonomy Code registered with DHS are allowed for use on Encounter data claims for covered entities. Proprietary Provider numbers are allowed for DHS enrolled Atypical Providers only.

(2) Diagnosis Codes

Contractor shall submit diagnostic coding using the most current listing of the DSM/ICD. DSM/ICD codes shall be reported to the highest level of specificity.

(3) Date(s) of Service

(4) Procedure Codes (HCPC or CPT Codes or other codes approved by DHS for use in submitting Encounter data)

(5) Number of Units of Service Provided

(6) Line item charge(s) based on Usual and Customary Charges, even though a Third Party Resource has made a complete or partial payment.

d. For Acute Inpatient Hospital Psychiatric Care Encounters, in addition to the identifying information listed in Subsection 2.b., Contractor is required to submit a HIPAA Compliant 837I format and the following minimum data elements for DHS processing of claims:

(1) The NPI as required by 45 CFR 162.412 for submissions

(2) Type of Admission Code

(3) Patient Discharge Status Code

(a) Contractor shall use discharge codes established by DHS in its Hospital Services Guide.

(b) If the OHP Member is found Appropriate for Long Term Psychiatric Care during the Acute Inpatient Hospital Psychiatric Care stay, Contractor shall use a discharge code of 05.

(4) Dates of Service (dates from admission through discharge)

(5) Revenue Codes

(a) Contractor shall use revenue codes specific to the services provided. If Contractor has a limited number of special "package" services for which it pays an all-inclusive fee and is unable to provide specific revenue codes for those services, Contractor may use revenue codes approved in advance by the DHS Technical/Encounter Data Services Subunit, Program Operations Unit.

(b) Contractor shall submit a list and description of packaged services to DHS for which Contractor is seeking a special revenue code. DHS may request additional information about "package" services or Encounters using "package" revenue codes at any time and may discontinue the use of "package" revenue codes at its discretion with 30 calendar days notice to Contractor.

(6) Line Item Charges

(7) Total Charges

(8) Diagnosis Code(s) at the highest level of specificity.

(9) ICD-9 Procedure Codes when a procedure is performed

(10) Attending Physician's NPI as required by 45 CFR 162.412 for submissions. The Provider's license number is not acceptable as a Provider number.

e. For Outpatient Hospital Encounters, in addition to the identifying information listed in Subsection 2.b., DHS requires an 837I format and the following minimum data elements for DHS processing of claims:

(1) The NPI as required by CFR 162.412 for submissions

(2) Revenue Center Code(s) (National Uniform Billing Committee (NUBC) Rule)

(3) Date of Service for each line item

(4) Quantity of units of service provided

(5) Line-item Charge(s) based on the usual and customary fee even though a Third Party Resource has made complete or partial payment.

(6) Diagnosis Code(s) at the highest level of specificity

(7) Procedure Codes for the Revenue Center Codes

(8) The NPI as required by 45 CFR 162.412 for submissions. The Provider's license number is not acceptable as a Provider number.

f. Contractors must submit one claim per hospitalization. The claim must represent all hospital services delivered to the OHP Member. Interim and late billings are prohibited. Additional services or revisions to the original claim must be handled through the adjustment process.

g. Contractors must make adjustments to claims when any required data elements change or Contractor discovers the data was incorrect or no longer valid.

h. Contractors must delete any duplicate claims within 63 calendar days of the date DHS notifies Contractor that the claim is a duplicate.

3. Data Certification and Validation

a. Contractor or designee must certify, based on best knowledge, information, and belief that the Encounter data submitted for OHP Members is accurate and complete.

b. Contractor shall submit the Data Certification and Validation Signature Authorization Form, Report H.1, within 30 days following the effective date of this Agreement, and immediately following any changes.

c. Contractor shall submit a Data Certification Form, Report H.2, with each Encounter submission.

d. Contractor shall submit a Claim Count Verification Acknowledgement and Action form, Report H.3, within ten (10) business days of receipt of the Out of Balance Data Verification Claim Count Verification Report Notice.

Attachments 1 through 4, entitled "Instructions for Report Forms H.1, H.2 and H.3" and Report Form H.1, Report Form H.2 and Report Form H.3 are attached hereto and incorporated herein by this reference.

4. Audit and Compare

MCO shall use the "Audit and Compare" feature of the 834 enrollment file. In the event there is a discovery of an out of balance file, Contractor shall contact the Oregon Health Plan (OHP) Mental Health Specialist (Prepaid Health Plan Coordinator) within 10 Business days of the day the inconsistency is found.

EXHIBIT H – Attachment 1
Instructions for Report Forms H.1, H.2 and H.3

1. Contractor shall demonstrate to DHS through proof of Data Certification and Validation that Contractor is able to attest to the accuracy, completeness and truthfulness of Information required by DHS. The requirements in this Exhibit 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. Contractor shall submit to DHS all reports specified in this Agreement and this Exhibit.

2. Required Data Certification and Validation Report Forms

Contractor shall submit the report forms listed below to DHS in the manner described in this Exhibit and on each form or report.

H.1 Signature Authorization Report Form
H.2 Data Certification and Validation Report Form
H.3 Claim Count Verification Acknowledgement and Action Report Form

Form H.2 – A Data Certification and Validation Report Form must be submitted concurrently with each Encounter Data submission. DHS will notify Contractor if Form H.2 does not meet the requirements.

Contractor shall submit missing or erroneous Report Form H.2 Data Certification and Validation Report Forms immediately upon notification from DHS 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 Agreement, 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 Exhibit B, Part VI, Section 2- Remedies Short of Termination in this Agreement.

After MMIS processing, DHS 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 DHS)

EXHIBIT H – Attachment 2
Report Form H.1 – Signature Authorization Form

This form is due within 30 days of effective date of this Agreement and immediately upon changes thereafter.

Contracted Plan

Name _____ OHP Assigned Plan Number: _____

Encounter Data information submitted to DHS must be certified by one of the following:

1. Chief Executive Officer, or similar top executive officer of the Contractor, however designated (CEO);
2. Chief Financial Officer, or similar top financial officer of the Contractor, however designated (CFO); or
3. An individual who has delegated authority to sign for and reports directly to the CEO or CFO.

_____ _____ _____
Print name and title of CEO or CFO Signature Date

As CEO or CFO I authorize the following designated person(s) to certify Encounter Data 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 DHS:

_____ _____
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 Report 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 DHS,

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 OHP Mental Health Specialist, 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
Report Form H.2 –Data Certification and Validation Report Form*

This form must be submitted concurrently with each Encounter Data 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	_____

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 DHS 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 DHS for processing (new, adjustments or deletes)

EXHIBIT H Attachment 4
Report Form H.3 - 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 DHS 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 individual who has authority to certify data by Report Form H.1, Signature Authorization Form.

_____ _____
Print Name Print Title

_____ _____
Signature Date

Exhibit I – Third Party Resources and Personal Injury Liens

Capitation rates(s) specified in this Agreement are based in part on projected third party recoveries. Contractor's failure to submit third party recovery data or pursue recoverable third party recovery obligations during the term of this Agreement may create a claim for reimbursement to the extent that would be limited to the requirements of federal law.

1. Contractor shall take all reasonable actions to pursue recovery of Third Party Resources for Covered Services provided during the period covered by this Agreement. "Third Party" means any individual, entity, or program that is, or may be, liable to pay all or part of the cost of any Covered Service furnished to an OHP Member and as defined in Exhibit A of this Agreement.

2. Contractor will develop and implement written policies describing its procedures for Third Party Resource recovery consistent 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. 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 an OHP Member might have other health insurance.

(2) Contractor shall immediately report that OHP 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 OHP Member's caseworker and the Department's Personal Injury Liens Unit, P.O. Box 14512, Salem, OR 97309-0416.

(3) To the extent authorized by law, the Department of Human Services will share client and claim information they receive with Contractor to assist in identifying Third Party Resources.

b. Determining the liability of Third Party Resource.

(1) Contractor shall request OHP Members to cooperate in securing payment from Third Party Resources, except when the client asserts good cause as defined in OAR 461-120-0350.

(2) If Contractor is unable to gain cooperation from the OHP Member or their authorized representative or a Third Party Resource in pursuing the Third Party Resource, or if the OHP Member 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. Cost-avoidance.

(1) Cost-avoidance is defined as a method for avoiding payment of Medicaid claims when Medicare or other insurance resources are available to the OHP 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 OHP Member or a Third Party Resource to obtain recovery from a Third Party Resource. Upon such notification, Contractor shall process the claim as a Valid Claim however, Contractor may pursue alternative remedies under Subsection b of this Section 2, or may seek to recover payment as provided in Subsection d of this Section 2.

d. Pay and Chase

Pay and Chase is defined as a method used where Contractor pays the claim and then attempts to recover from liable Third Party Resources.

e. Procedures for identifying and requesting payment from a Third Party Resource that applies to a personal injury.

(1) Contractor's recourse for obtaining timely assignment of the rights to recovery or the 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 an OHP Member or their representative.

(2) When another party may be liable for a personal injury, Contractor may make the payments and (consistent with Paragraph a, of this Subsection 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 OHP Member or their financially 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 review and review consistent with the provisions of this Agreement.

(1) Contractor shall report all Third Party Resource payments to AMH using Report G.2, Current OHP Members with Third Party Resources (Quarterly Report), on a quarterly basis within 60 calendar days after the end of each calendar quarter.

(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 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 OHP 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 AMH discretion or at the request of the Contractor, AMH may retroactively disenroll an OHP Member to the time the OHP Member acquired Third Party Resource insurance. If the Member's Enrollment is inconsistent with OHP managed care Enrollment rules 410-141-0060 through 410-141-0080, an OHP Member is retroactively disenrolled and AMH will Recoup all Capitation Payments to Contractor after the effective date of the Disenrollment. Contractor and its Subcontractors may not seek to collect from the OHP Member (or any financially responsible representative of the OHP 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 an OHP 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 AMH, described in Section 2, Subsection f, Paragraph (1), of this Exhibit.

6. When engaging in Third Party Resource recovery actions, Contractor and Subcontractors shall comply with federal and state confidentiality requirements pursuant to Exhibit E, Section 7, (HIPAA), including without limitation, the federal (42 CFR Part 2) and state (ORS 426.460 and ORS 179.505) confidentiality laws and regulations governing the identity and client records of OHP Members. AMH considers the disclosure of OHP 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

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. This may include operational policies and controls in areas such as complaint and Grievance resolution, provider Credentialing and contracting, provider and staff education, and corrective action plans to prevent potential fraud and abuse activities. Contractor shall review its fraud and abuse policies annually. If Contractor is also a Medicare contractor, the fraud and abuse policies established by Contractor to meet CMS standards shall be deemed sufficient to meet DHS' requirements for fraud and abuse prevention and monitoring. 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 agreement.

1. Contractor's fraud and abuse activities shall include, at minimum, the following:

a. Written policies, procedures, and standards of conduct that articulate Contractor's commitment to comply with all applicable Federal and state standards to guard against fraud and abuse;

b. 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 Agreement 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.

c. Provide as part of the written policies, detailed provisions regarding the Contractor's policies and procedures for detecting and preventing fraud, waste and abuse.

d. Include in any employee handbook for the Contractor, a specific discussion of the laws described in Subsection b., of this section, the rights of employees to be protected as whistleblowers, and the Contractor's policies and procedures for detecting and preventing fraud, waste and abuse.

e. The designation of a compliance officer and a compliance committee that are accountable to senior management, to monitor fraud and abuse activities;

f. Effective training and education for the compliance officer and Contractor's employees;

g. Effective lines of communication between the compliance officer and Contractor's employees;

h. Enforcement of standards that guard against fraud and abuse through well publicized disciplinary guidelines;

i. Provision for internal monitoring and auditing; and

j. Provision for prompt response to detected offenses and for development of corrective action initiatives relating to this MHO Agreement.

2. Services under this Agreement may not be provided by the following persons (or their affiliates as defined in the Federal Requisition Regulations): (a) Persons 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 who are currently excluded from the Medicaid participation under Section 1128 or Section 1128A of the Act.

3. Contractor shall not refer OHP Members to such persons and shall not accept billings for services to OHP Members by such persons.

4. Contractor may not knowingly: (1) have a person described in (a) above as a director, officer, partner, or person with beneficial ownership of more than 5% of Contractor's equity, or (2) have an employment, consulting, or other agreement with a person described in 1(a) above for the provision of items and services that are significant and material to Contractor's obligations under this Agreement.

5. Contractor is required to promptly refer all verified cases of fraud and abuse, including fraud by employees and Subcontractors of the organization to the Medicaid Fraud Control Unit (MFCU), consistent with the Memorandum of Understanding between DHS and the MFCU. Contractor may also refer cases of suspected fraud and abuse to the MFCU prior to verification.

6. Examples of cases that should be referred:

a. Providers who consistently demonstrate a pattern of intentionally reporting encounters or services that did not occur. A pattern would be evident in any case where 20% or more of sampled or audited services are not supported by documentation in the Clinical Records;

b. Providers who consistently demonstrate a pattern of intentionally reporting overstated or up-coded levels of service. A pattern would be evident by 20% or more of sampled or audited services that are billed at a higher level procedure code than is documented in the Clinical Records;

c. Any verified case where the provider purposefully altered, falsified, or destroyed Clinical Record documentation for the purpose of artificially inflating or obscuring compliance rating or collecting Medicaid payments not otherwise due;

d. Providers who intentionally or recklessly make false statements about the credentials of persons rendering care to OHP Members;

e. Providers who intentionally fail to render Medically Appropriate Covered Services to OHP Members;

f. Providers who knowingly charge OHP Members for services that are covered or intentionally balance bill an OMAP Member the difference between the service charge and Contractor's payment, in violation of DHS rules;

g. Any case of theft, embezzlement or misappropriation of Title XIX or Title XXI program money.

7. An incident with any of the referral characteristics listed above should be referred to the MFCU. Contractor may also refer cases of suspected fraud and abuse to the MFCU.

8. The MFCU phone number is (971) 673-1880, address 1515 SW 5th Avenue, Suite 410, Portland, Oregon 97201, and fax (971) 673-1890.

9. Incidents of verified or suspected fraud or abuse by an OHP Member should be reported to DHS Fraud Investigation Unit, P.O. Box 14150, Salem, Oregon 97309-5027, phone number (503) 378-6826, facsimile number (503) 373-1525.

10. Contractor shall promptly report all fraud and abuse as required under this section to the MFCU. Contractor shall also notify DHS of referrals to MFCU of complaints of fraud and abuse that warrant investigation. This notification shall include the following information:

11. Contractor shall promptly report all fraud and abuse as required under this section to the MFCU. Contractor shall also notify DHS of referrals to MFCU of complaints of fraud and abuse that warrant investigation. This notification shall include the following information:

a. Provider's name, Oregon Medicaid Provider Number, and address;

b. Type of Provider

c. Source of complaint;

d. Nature of complaint;

e. The approximate range of dollars involved;

f. The disposition of the complaint when known; and

g. Number of complaints for the time period.

12. Contractor shall cooperate with the MFCU and the DHS Fraud Unit and allow them to inspect, evaluate, or audit books, records, documents, files, accounts, and facilities as required to investigate an incident of fraud or abuse.

13. In the event that Contractor reports suspected fraud, or learns of an MFCU or DHS Fraud Unit investigation, Contractor shall not notify or otherwise advise its subcontractors of the investigation so as not to compromise the investigation.

Exhibit K – Mental Health Services Capacity Assurance Report

1. Contractor shall submit the Mental Health Services Capacity Assurance Report as described in this Exhibit K to AMH within one calendar month after the effective date of this Agreement. Contractor may complete a separate report for each county included in its Service Area.

2. Contractor shall list the names of all Participating Outpatient Providers contracted with for the provision of Covered Services under this Agreement.

   a. Contractor shall include the names of those employed persons whose duties may be administrative if such persons are responsible for oversight of clinical or Case Management activities; however, the amount of time recorded for such persons shall be limited to the proportion of time spent conducting clinical oversight or Case Management activities.

   b. Contractor shall indicate the average number of hours worked each week over the last three (3) months for Contractor employed Health Care Professionals. A "standard" work week, for the purposes of this report, shall be 40 hours.

      (1) Contractor may prorate the average number of hours worked each week using the following formula: the number of hours worked x percentage of OHP Members seen. For example, if 85% of total clients are OHP Members, multiply the total hours worked by each employed Health Care Professional by 85%.

      (2) Contractor may propose to AMH other methods to calculate the average number of hours per week by employed Health Care Professionals.

   c. For contracted Health Care Professionals, Contractor shall indicate the average number of hours worked each week over the last three (3) months in providing Covered Services to OHP Members.

3. Contractor's report shall include the following data elements:

   a. Name of MHO

   b. Report Date

   c. County, or counties, to which this report applies

   d. List name of each contracted individual mental health professional providing Covered Services to OHP Members by degree or license and indicate specialty using the following categories:

(1) MD/PMHNP (Physician/Psychiatrist/Psychiatric Mental Health Nurse Practitioner),

(2) PhD (Licensed Clinical Psychologist),

(3) LCSW (Licensed Clinical Social Worker), or

(4) Non-English language spoken by individual Provider.

e. List name of each contracted agency showing employed clinical persons providing Covered Services or Case Management activities, and indicate the average hours per week each is engaged in OHP activities for the Contractor. Use the following categories:

(1) MD/PMHNP (Physician/Psychiatrist/Psychiatric Mental Health Nurse Practitioner),

(2) PhD (Licensed Clinical Psychologist),

(3) LCSW (Licensed Clinical Social Worker),

(4) QMHP (Qualified Mental Health Professional),

(5) QMHA (Qualified Mental Health Associate),

(6) PARA/Non-D (Paraprofessional/Non-Degree), or

(7) Non-English language spoken by individual Provider.

f. List the names of all other Participating Providers not included above with whom the Contractor has subcontracted for the provision of Covered Services under this Agreement including, but not limited to, psychiatric residential and day treatment facilities, hospitals, or Respite Care Providers. These Providers are to be listed at facility level only.

g. Non-English language spoken by providers.

4. Contractor shall send this report to AMH, Medicaid Policy Unit, 500 Summer St. NE, E86, Salem, OR 97301-1118.

5. If Contractor has questions about this report, Contractor may call the AMH OHP Mental Health Specialist at (503) 947-5530.

Exhibit L – Mental Health Organization (MHO) Grievance Log

1. Grievance means an oral or written communication, submitted by an OHP Member or an OHP Member Representative, which addresses issues with any aspect of the Contractor's or Provider's operations, activities, or behavior that pertains to 1) the availability, delivery, or Quality of Care, including Utilization review decisions, that are believed to be adverse by the OHP Member; or 2) the denial, reduction, or limitation of Covered Services under this Agreement. The expression may be in whatever form or communication or language that is used by the OHP Member or the OHP Member Representative, but must state the reason for the dissatisfaction and the OHP Member's desired resolution.

2. An OHP Member, or OHP Member Representative, may relate any incident or concern to Contractor, Provider, or Subcontractor, by indicating or expressing dissatisfaction or concern, or by stating this is a Grievance that needs resolution.

3. Grievances are a source of information that may be used to evaluate the quality of access, Provider service, clinical care, or Contractor Service to OHP Members. Contractor shall have written policies and procedures for the thorough, appropriate and timely resolution of OHP Member Grievances, which include:

   a. Documentation of the nature of the Grievance which shall include, at minimum:

      (1) A log of formal Grievances;

      (2) A file of written formal Grievances, and

      (3) Records of their resolution.

   b. Analysis and investigation of the Grievance; and

   c. Notification to the OHP Member of the disposition of the Grievance and the OHP Member's right to appeal the outcome of the Grievance or handling of a Grievance.

4. Contractor shall complete and submit the MHO Grievance Log on a quarterly basis within 60 calendar days of the end of each calendar quarter. Contractor shall record each Grievance once on the MHO Grievance Log. If the Grievance covers more than one category, Contractor shall record the Grievance in the predominant category.

5. Contractor shall send the MHO Grievance Log to AMH, Medicaid Policy Unit, 500 Summer St. NE, E86, Salem, OR 97301-1118.

6. If Contractor has questions about this report, Contractor may call the AMH OHP Mental Health Specialist at (503) 947- 5530.

2008 OHP MHO Agreement – Effective January 1, 2008 -

MHO Grievance Log

MHO:_____ Year:_____

Report Period (circle): Jan-Mar Apr-Jun Jul-Sep Oct-Dec

Grievance: An oral or written communication, submitted by an OHP Member or an OHP Member Representative, which addresses issues with any aspect of the Contractor's or Provider's operations, activities, or behavior that pertains to the availability, delivery, or Quality of Care including Utilization review decisions that are believed to be adverse by the OHP Member. The expression may be in whatever form or communication or language that is used by the OHP Member or the OHP Member Representative, but must state the reason for the dissatisfaction and the OHP Member's desired resolution.

Client/Rep Identifier *1	Date Received	Grievance Type *2	Disposition: Select One - Resolved / Appeal Requested / Hearing Requested	Disposition Date	# Days to Disposition *3

*1: Contractor/Subcontractor must track client/representative identity, but may choose not to include identifier in submitted Grievance logs.

*2: A=Access
I=Interaction with Provider, Contractor or Staff
D=Denial of Service, Authorization or Payment
Q=Quality of Service
C=Clinical Care
CR=Consumer Rights

*3: Count of calendar days begins with the receipt date and does not include the final date of disposition. (For example, if a Grievance is received Thursday,

January 4, 2007 and disposed of Tuesday, January 9, 2007, the # of calendar days would be 5-days).

This document is not <u>all inclusive</u> of the monitoring/tracking responsibilities related to Grievances of the MHO.

Exhibit M – Practitioner Incentive Plans

1. Contractor shall comply with all requirements of this Exhibit to ensure compliance with Sections 4204(a) and 4731 of the Omnibus Budget Reconciliation Act of 1990 that concern practitioner incentive plans. The purpose of this Act is to ensure that OHP Members are not being denied access to Medically Appropriate referral services based on financial incentives. Contractor shall not set into place any financial incentives which reduce or limit provision of Covered Services to OHP Members as specified in this Agreement.

2. Contractor shall complete and submit to AMH Report M.1: Practitioner Incentive Plan Disclosure, under the following circumstances:

   a. On the effective date of this Agreement;

   b. At least 45 calendar days before the effective date of changes to the referral incentive arrangements which results in a change in the amount of risk or Stop Loss Protection or a change in the risk formula to include coverage of services not provided by the practitioner or practitioner group which were not previously included in the formula;

   c. Within 30 calendar days of AMH request; and

   d. On the effective date of any amendment to this Agreement that extends Contractor's Service Area.

3. Contractor shall provide to any OHP Member who requests it the following information:

   a. Whether the Contractor uses a practitioner incentive plan that affects the use of referral services;

   b. The type of incentive arrangement;

   c. Whether Stop Loss Protection is provided; and

   d. If a survey is required to ensure access to services is not being denied based on the practitioner incentive plan, a summary of the survey results.

4. If Contractor practitioner incentive plans meet the definition appearing in Report M.1: Practitioner Incentive Plan Disclosure, Contractor shall complete and submit to AMH, on the effective date of this Agreement and at least 45 calendar days before the effective date of changes to the practitioner incentive plans, Report M.2: Practitioner Incentive Plan Detail. AMH will use information reported to determine whether Contractor incentive arrangements place the practitioner or practitioner group at risk for amounts beyond a specified risk threshold.

   a. Risk threshold means the maximum risk to which a practitioner or practitioner group may be exposed under a practitioner incentive plan without being at substantial financial risk. It applies to incentive arrangements involving referral services. The specified risk threshold is set at 25 percent of potential earnings of the practitioner or practitioner group.

b. Substantial financial risk applies to those practitioners and practitioner groups with a patient panel size of less than 25,001 OHP Members or a patient panel size of more than 25,000 OHP Members as a result of pooling OHP Members. A substantial financial risk exists for these practitioners and practitioner groups if the incentive arrangement described above in 4.a. places the practitioner or practitioner group at risk of losing more than the risk threshold.

c. An incentive arrangement shall be determined as causing substantial financial risk under the following circumstances:

(1) Withholds are greater than 25 percent of the maximum anticipated total incentive payments (salary, FFS payments, Capitation Payments, returned withhold and bonuses);

(2) Withholds less than 25 percent of potential payments if the practitioner or practitioner group is potentially liable for amounts exceeding 25 percent of potential payments;

(3) Bonus that is greater than 33 percent of potential payments minus the bonus;

(4) Withholds plus bonuses if this sum equals more than 25 percent of potential payments. The threshold bonus percentage for a particular withhold percentage may be calculated using the formula:

withhold percentage - 0.75(bonus percentage)+25%

(5) For Capitation arrangements, if the difference between the maximum possible payments and minimum possible payments is more than 25 percent of the maximum possible payments; or the maximum and minimum possible payments are not clearly explained in the practitioner's or practitioner group's contract; and

(6) Any other incentive arrangements that have the potential to hold a practitioner or practitioner group liable for more than 25 percent of potential payments.

5. If Contractor is found to have referral incentive arrangements which place its practitioners or practitioner groups at substantial financial risk, Contractor shall conduct a survey of OHP Members to address satisfaction with the quality of services provided and degree of access to the services. Such survey may be conducted as part of survey administration occurring based on Contractor's QA Program. Contractor shall provide AMH with survey data and results within 60 calendar days of the survey due date. The survey shall:

a. Include either all current OHP Members of Contractor and those who have disenrolled for reasons other than loss of eligibility or relocation outside the service Areas; or all those OHP Members enrolled during the past twelve months or a sample of these OHP Members;

b. Be designed, implemented and analyzed in accordance with commonly accepted principles of survey design and statistical analysis;

c. Address the satisfaction of OHP Members and disenrolled OHP Members with the quality of services provided and their degree of access to the services; and

d. Be conducted no later than one year after the effective date of the incentive arrangement and at least every two years thereafter.

6. Contractor shall ensure that all practitioners and practitioner groups determined to be at substantial financial risk have either aggregate or per OHP Member Stop Loss Protection in accordance with the following requirements:

a. If aggregate Stop Loss Protection is provided, Contractor shall cover 90 percent of referral service costs (beyond allocated amounts) that exceed 25 percent of potential earnings of the practitioner or practitioner group; or

b. If per patient Stop Loss Protection is provided, Contractor shall provide Stop Loss Coverage based on patient panel size as reflected in the following table:

Patient Panel Size	Per Patient Stop Loss Limit
Less than 1,000	$10,000
1,000 to 10,000	$30,000
10,001 to 25,001	$200,000
More than 25,000 (No Pooling)	No specification
More than 25,000 (Pooling)	$200,000

7. CMS may impose a penalty of up to $25,000 in addition to or in lieu of other remedies available under law if CMS determines that the Contractor either misrepresented or falsified information furnished to AMH or an OHP Member in regard to the Practitioner Incentive Plan provisions or failed to comply with the Practitioner Incentive Plan provisions specified in this Agreement.

8. DHS will suspend payment for new OHP Members until it is satisfied that the basis for the determination by CMS is not likely to recur.

Exhibit M – Attachment 1
Report M.1: Practitioner Incentive Plan Disclosure

MHO: _____ Date Prepared: _____

Signature and Title of Authorized Representative: _____

Practitioner Incentive Plan: Any incentive arrangement between an eligible organization and a practitioner or practitioner group that may directly or indirectly have the effect of reducing or limiting Covered Services furnished with respect to individuals enrolled in the organization. The compensation arrangement may include a variety of payment methods that create financial incentives to influence the use of referral services which are arranged, but not directly provided, by the practitioner subject to the practitioner incentive plan. Such incentive arrangements may hold a practitioner or a practitioner group at risk for all or a portion of the cost of referral services and may provide additional compensation to the practitioner or practitioner group if the practitioner or practitioner group is successful at controlling the level of referral services.

Question or Requirement		Response
1.	Does said organization use practitioner incentive plans as defined above for work performed under this Agreement?	
2.	If the answer to item 1 is yes, answer these additional questions.	
	a. Does the plan reference services that are not provided by the practitioner or practitioner group?	
	b. Does the plan involve a withhold and/or bonus?	
	If yes, what is the percent or dollar amount of the withhold and/or bonus?	
	c. Does the plan require Stop Loss Protection?	
	If yes, what type of stop loss is required?	
	If yes, what amount of protection is required?	

<table>
<tr><th colspan="2">Question or Requirement</th><th colspan="2">Response</th></tr>
<tr><td>d.</td><td>What is the patient panel size?

If the panel size is based on a pooling of patients, describe the pooling method used.</td><td colspan="2"></td></tr>
<tr><td>e.</td><td>Does the plan involve Capitation of practitioners or groups?

If yes, complete the table to the right using information from the most recent year.</td><td>Practitioner Type</td><td>Percent of Total Capitation Paid</td></tr>
<tr><td></td><td></td><td>PCPs</td><td></td></tr>
<tr><td></td><td></td><td>Referral Services to Specialists</td><td></td></tr>
<tr><td></td><td></td><td>Hospital</td><td></td></tr>
<tr><td></td><td></td><td>Other Types of Providers Services</td><td></td></tr>
<tr><td></td><td></td><td>Total</td><td></td></tr>
<tr><td>f.</td><td>Does said organization conduct surveys of OHP Members to measure the impact of practitioner incentive plans on quality of services and access to services?

If yes, when was the last survey conducted and who was surveyed?

If yes, when will the next survey be conducted and who will be surveyed?

If yes, describe how the survey was designed, implemented and analyzed.</td><td colspan="2"></td></tr>
</table>

DHS-OHP-0510-3/98

Exhibit M – Attachment 2
Report M.2: Practitioner Incentive Plan Detail

MHO: _____ Date Prepared: _____

Provider Type	Patient Panel Size	Service Payments				Incentives					Total Service Payments and Incentives	Practitioner Liability
		Salary	Fee-for-Service	Capitation	Total	Bonus	Capitation Withhold	FFS Withhold	Referral Withhold	Total		
Primary Care Practitioners												
Referral Services to Specialists												
Hospital												
Other Types of Providers Services												
Total												

Instructions:

1. Provide the total aggregate amount of payment made by Contractor to each provider type by service payment and incentive arrangement for services delivered under this Agreement during the risk/incentive period.

2. If any one particular referral provider comprises 25% or more of any referral incentive arrangement, then provide the name, address and phone number of the provider group.

3. Provide a written, signed and dated statement and justification if any of the above information is to be considered confidential.

Other Definitions for Report M.2 – Practitioner Incentive Plan Detail

Bonus: A payment made to a practitioner or practitioner group beyond any salary, FFS payments, capitation, or returned withhold.

Capitation Withhold: An incentive arrangement where a certain amount is removed from the negotiated Capitation Payment and might or might not be returned to the Participating Providers within the health care delivery system to cover a specified set of services and administrative costs at a given point in time on the basis of certain criteria and/or factors.

Fee-for-Service Withhold: An incentive arrangement where a certain percentage of the service fee is removed from the base amount of the service fee and might or might not be returned to the Participating Providers within the health care delivery system on the basis of certain criteria and/or factors.

Practitioner Liability: An incentive arrangement where payments are made to or by Participating Providers within the health care delivery system at a given point in time on the basis of certain performance criteria. Practitioner liability does not include those items defined elsewhere on this page.

Referral: Any specialty, inpatient, outpatient, or laboratory services that a practitioner or practitioner group orders or arranges, but does not furnish directly.

Referral Withhold: An arrangement between Contractor and Participating 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 referral health care services to Contractor's OHP Members. These arrangements consist of any amounts Contractor pays Participating Providers for services provided, including the amounts paid for administration. These arrangements may control levels or costs of referral services. These payments should only include arrangements based on referral levels. Arrangements made between Contractor and an intermediate entity who in turn subcontracts with one or more practitioner groups are to be reported.

Exhibit N - MHO Grievance System

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 through 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 through OAR 410-141-0266.

b. Contractor shall provide information to all OHP Members that includes at least:

(1) Written material describing the Contractor's Grievance, Appeal and Expedited Appeals procedures, and how to make a Grievance or file an Appeal or Expedited Appeal; and

(2) Assurance in all written, oral, and posted material of OHP Member confidentiality in the Grievance and Appeal processes.

c. An OHP Member or an OHP Member's Representative may file a Grievance and a Contractor level Appeal orally or in writing, and may request an Administrative Hearing.

d. Contractor shall keep all information concerning an OHP Member's Grievance 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 Grievances or Appeals, or both, shall begin to obtain documentation of the facts concerning the Grievance or Appeal upon receipt of the Grievance or Appeal.

f. Contractor shall afford OHP Member's full use of the Grievance System procedures. If the OHP Member decides to pursue a remedy through the Administrative Hearing process, the Contractor shall cooperate by providing to AMH, relevant information that may be required for the Administrative Hearing process.

g. Contractor shall treat as an Appeal an OHP Member's request for an Administrative Hearing made to AMH outside of the Contractor's Appeal procedures, or without previous use of the Contractor's Appeal procedures, upon notification by AMH as provided for in OAR 410-141-0264.

h. Under no circumstances shall Contractor discourage an OHP Member or an OHP Member's Representative from using the Administrative Hearing process.

i. Contractor shall not request Disenrollment of an OHP Member on the basis of implementation of an Administrative Hearing decision or an OHP Member's request for an Administrative Hearing.

j. Contractor shall as specified in OAR 410-141-0260, Section 12, make available a supply of blank Grievance forms (OHP 3001) in all Contractor administrative offices and in those medical offices where staff have been designated by the Contractor to respond to Grievances.

Contractor shall develop an Appeal form and shall make the forms available in all Contractor administrative offices and in those medical offices where staff have been designated by the Contractor to respond to Appeals.

k. The Contractor shall provide information about the Grievance System, as outlined in this Exhibit, 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 Grievances and Appeals received by the Contractor, and Contractor shall review the information as part of its Quality Improvement strategy.

m. An authorized OHP Member Representative, pursuant to 42 CFR 438.402(b) (ii), may act for the OHP Member at any stage in the Grievance System. Contractor shall document the basis on which an individual acts as Representative of the OHP Member.

2. Contractor Grievance Procedures

a. A Grievance procedure applies only to those situations in which the OHP Member or OHP Member's Representative expresses concern or dissatisfaction about any matter other than an "Action." As per 42 CFR, 438.408, Contractor shall have written procedures to acknowledge the receipt, disposition and documentation of each Grievance from OHP Members. The Contractor's written procedures for handling Grievances, shall, at a minimum:

(1) Address how the Contractor will accept, process and respond to each Grievance from an OHP Member or OHP Member's Representative, including:

(a) Acknowledgment to the OHP Member or OHP Member Representative of receipt of each Grievance.

(b) Ensuring that OHP Members who indicate dissatisfaction or concern are informed of their right to file a Grievance and how to do so;

(c) Ensuring that each Grievance is transmitted timely to staff that have authority to act upon it;

(d) Ensuring that each Grievance is investigated and resolved in accordance with all applicable rules; and

(e) Ensuring that the Contractor's staff person(s) who makes decisions on the Grievance must be persons who are:

(i) Not involved in any previous level of review or decision-making;

(ii) Health Care Professionals who have appropriate clinical expertise in treating the OHP Member's condition or disease, if the Grievance concerns denial of expedited resolution of an Appeal or if the Grievance involves clinical issues; and

(iii) Qualified to make denials based on lack of medical necessity.

(2) Describe how the Contractor informs OHP Members, both orally and in writing (OAR 410-141-(G)(b)), about the Contractor's Grievance procedures;

(3) Designate the Contractor's staff member(s) or a designee who shall be responsible for receiving, processing, directing, and responding to Grievances;

(4) Include a requirement for Grievances 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 OHP Members with any reasonable assistance in completing forms and taking other procedural steps related to filing and disposition of a Grievance. 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 OHP Members that Grievances 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 OHP Member's right to confidentiality of information about the Grievance as follows:

(1) Contractor shall implement and monitor written policies and procedures to ensure that all information concerning an OHP Member's Grievance 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. As specified in OAR 410-141-0261 (3)(a), the Contractor and any Provider whose Services, items or Quality of Care is alleged to be involved in the Grievance have a right to use this information for purposes of the Contractor resolving the Grievance, for purposes of maintaining the log required in OAR 410-141-0266, and for health oversight purposes, without a signed authorization from the OHP Member;

(2) Except as provided in Subsection (1) or as otherwise permitted by all other applicable confidentiality laws, Contractor shall ask the OHP Member to authorize a release of information regarding the Grievance to other individuals as needed for resolution. Before any information related to the Grievance is disclosed under this subsection, the Contractor shall have an authorization for release of information documented in the Grievance 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 Grievances within the following timeframes:

(1) The Contractor shall resolve each Grievance, and provide notice of the disposition, as expeditiously as the OHP Member's health condition requires, within the timeframes established below;

(2) For standard disposition of Grievances and notice to the affected parties, within 5 working days from the date of the Contractor's receipt of the Grievance, the Contractor shall either:

(a) Make a decision on the Grievance and notify the OHP Member; or

(b) Notify the OHP Member in writing that a delay in the Contractor's decision, of up to 30 calendar days from the date the Grievance was received by the Contractor, is necessary to resolve the Grievance. The written notice shall specify the reasons the additional time is necessary.

e. The Contractor's decision about the disposition of a Grievance shall be communicated to the OHP Member orally or in writing within the timeframes specified in Section 2, Subsection d of this Exhibit:

(1) An oral decision about a Grievance shall address each aspect of the OHP Member's Grievance and explain the reason for the Contractor's decision;

(2) A written decision must be provided if the Grievance was received in writing. The written decision on the Grievance shall review each element of the OHP Member's Grievance and address each of those concerns specifically, including the reasons for the Contractor's decision.

f. All Grievances made to the Contractor's staff person designated to receive Grievances 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 Grievances that the OHP Member chooses to resolve through another process, and that the Contractor is notified of, shall be noted in the Grievance log.

h. An OHP Members who is dissatisfied with the disposition of a Grievance may present the Grievance to the OHP Client Advisory Services Unit (CASU).

3. Contractor Appeal Procedures

a. The Contractor shall have a system in place for OHP Members that includes an Appeal process related to Actions. As defined in Exhibit A of this Agreement, an Appeal means a request to the Contractor for review of an Action, as those capitalized terms are defined in the Contract. An OHP Member must complete the Contractor's Appeal process before requesting an Administrative Hearing. If the OHP 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 OHP Member or OHP Member's Representative, or a Provider acting on behalf of the OHP 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 OHP 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 OHP 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 OHP Member's condition or disease, if an Appeal of a denial is based on lack of Medical Appropriateness or if an Appeal involves clinical issue.

(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 OHP 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 OHP 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 an OHP 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 are 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 AMH, without a signed authorization from the OHP Member. The information may also be disclosed to AMH if the OHP Member requests an Administrative Hearing regarding the Appeal without a signed authorization from the OHP Member, pursuant to OAR 410-120-1360 (4);

(2) Except as provided in Subsection (1) or as otherwise permitted by all other applicable confidentiality laws, Contractor shall ask the OHP 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 OHP 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 OHP Member or the OHP Member's Representative of the limited time available in the case of an expedited resolution);

(3) Provide the OHP Member and the OHP Member's Representative an opportunity, before and during the Appeals process, to examine the OHP 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 OHP Member and the OHP Member's Representative, or the legal Representative of a deceased OHP 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 OHP 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 OHP Member or OHP Member's Representative no later than 45 days from the day the Contractor receives the Appeal. This timeframe may be extended pursuant to Subsection (3) of this section;

(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 OHP Member or OHP Member's Representative no later than 3 working days after the Contractor receives the Appeal. This timeframe may be extended pursuant to Subsection (3) of this section;

(3) The Contractor may extend the timeframes from subsections (1) or (2) of this section by up to 14 calendar days if:

(a) The OHP Member requests the extension; or

(b) The Contractor shows (to the satisfaction of AMH, upon its request) that there is need for additional information and how the delay is in the OHP Member's interest.

(4) If the Contractor extends the timeframes, it shall, for any extension not requested by the OHP Member, give the OHP 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 OHP Member or the OHP Member 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 OHP 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 an Administrative Hearing, and how to do so, which includes attaching the "Notice of Hearing Rights" (DMAP 3030) and the "Administrative Hearing Request" (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/databases/FMPRO?-db=FormTbl.fp5&-lay=Main&-format=Findforms_FMP.htm&-findany ;

(c) The right to request to receive benefits while the hearing is pending, and how to make the request; and

(d) That the OHP Member may be held liable for the cost of those benefits if the hearing decision upholds the Contractor's Action.

j. An OHP Member may request an Administrative Hearing not later than 45 days from the date on the Contractor's notice of Appeal resolution, consistent with Section 3, Subsection g, Paragraph (1) of this Exhibit. The parties to the Administrative Hearing include the Contractor as well as the OHP Member and OHP Member's Representative, or the Representative of the deceased OHP 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 OHP Member's benefits if:

(a) The OHP Member or OHP Member's 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 OHP Member requests extension of benefits.

(3) Continuation of benefits pending Administrative Hearing – If, at the OHP Member's request, the Contractor continues or reinstates the OHP Member's benefits while the Appeal is pending and the notice of Appeal resolution is adverse to the OHP 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 OHP Member, that is, upholds the Contractor's Action, the Contractor may recover from the OHP Member the cost of the Services furnished to the OHP Member while the Appeal was pending, to the extent that they were furnished solely because of the requirements of Section 3, Subsection m, Paragraph (2) of this Exhibit 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 OHP Member's favor, even if the OHP 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 OHP Member's health condition requires.

(2) If the Contractor reverses a decision to deny authorization of Services, and the OHP Member received the disputed Services while the Appeal was pending, the Contractor or AMH shall pay for the Services in accordance with AMH 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 Exhibit to the OHP Member within the timeframes specified in Section 4, Subsection c of this Exhibit.

b. The written Notice of Action must be an AMH 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 Exhibit B, Part III, Section 1, entitled "Informational Materials and Education of OHP Members and Potential OHP Members," and must inform the OHP Member of the following:

(1) Relevant information including, but not limited to, the following:

(a) Date of Notice of Action;

(b) Contractor name;

(c) Provider name;

(d) OHP 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 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 an OHP Member at the time of the Service or is not an OHP 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 Oregon Health Plan 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 Section 4, Subsection b, of this Exhibit;

(5) The OHP 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 OHP 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 OHP 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 Section 4, Subsections c, Paragraph (1), Items (b) or (c) 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 OHP 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 OHP Member has been admitted to an institution where he or she is ineligible for Covered Services from the Contractor;

(iii) The OHP 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 OHP Member for Medicaid services;

(v) There is a change in the level of medical care that is prescribed by the OHP Member's Provider;

(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 OHP 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 OHP Member's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the OHP Member's urgent medical needs, or an OHP 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 on the part of the OHP 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 OHP 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 OHP Member or the Provider requests the extension; or if the Contractor justifies (to AMH upon request) a need for additional information and how the extension is in the OHP Member's interest;

(b) If the Contractor extends the timeframe, in accordance with Section 4, Subsection c, Paragraph (3), Item (a) of this Exhibit, it shall give the OHP Member written notice of the reason for the decision to extend the timeframe and inform the OHP Member of the right to file a Grievance if he or she disagrees with that decision. The Contractor shall issue and carry out its prior authorization determination as expeditiously as the OHP Member's health condition requires and no later than the date the extension expires.

d. For prior authorization decisions not reached within the timeframes specified in Section 4, Subsection c, Paragraph (3) of this Exhibit, (which constitutes a denial and is thus an adverse Action), on the date that the timeframes expire;

e. For expedited prior authorizations, within the timeframes specified in OAR 410-141-0265.

5. Contractor Responsibilities in Relation to Administrative Hearings

a. An individual who is or was an OHP Member at the time of the Notice of Action is entitled to an Administrative Hearing by AMH regarding a notice of Appeal resolution by Contractor that did not resolve the Appeal wholly in favor of the OHP Member. The OHP 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 OHP 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 OHP 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 OHP Member, unless the OHP Member within the 10-day timeframe, has requested an Administrative Hearing with continuation of benefits until the Administrative Hearing decision is reached;

(3) A final order is issued in an Administrative Hearing adverse to the OHP Member; or

(4) The time period or Service limits of a previously authorized Service have been met.

c. Contractor shall immediately transmit to AMH any Administrative Hearing request submitted on behalf of an OHP Member, including a copy of the OHP Member's notice of Appeal resolution.

d. If the OHP Member files a request for an Administrative Hearing with AMH, AMH 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 OHP Member.

f. When an Administrative Hearing is requested by an OHP Member who has exhausted the Contractor's Appeal process, the Contractor shall cooperate with providing relevant information required for the Administrative Hearing process to AMH, 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 OHP Member, that is, if the final order upholds the Contractor's Action, the Contractor may recover the cost of the Services furnished to the OHP 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 OHP Member, or AMH or the Contractor decides in the OHP Member's favor before the Administrative Hearing even if the OHP 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 an 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 OHP Member's health condition requires;

(2) If the Contractor, or the Administrative Hearing decision reverses a decision to deny authorization of Services, and the OHP Member received the disputed Services while the Administrative Hearing was pending, the Contractor shall pay for the Services in accordance with AMH policy and regulations in effect when the OHP 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 OHP Member) or the Provider indicates (in making the request on an OHP Member's behalf or supporting the OHP Member's request) that taking the time for a standard resolution could seriously jeopardize the OHP 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 an OHP Member's Appeal.

c. If the Contractor provides an expedited Appeal, but denies the Services or items requested in the expedited Appeal, the Contractor shall inform the OHP Member of the right to request an expedited Administrative Hearing and shall provide the OHP Member with a copy of both the "Administrative Hearing Request" (DHS 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/databases/FMPRO?-db=FormTbl.fp5&-lay=Main&-format=Findforms_FMP.htm&-findany ;

d. 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 OHP 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 an OHP Member, who believes that taking the time for a standard resolution of a request for an Administrative Hearing, could seriously jeopardize the OHP Member's life or health or ability to attain, maintain or regain maximum function, to request an expedited Administrative Hearing.

e. The Contractor shall submit relevant documentation to AMH's Medical Director within, as nearly as possible, two working days following the OHP 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 Grievances and Appeals received by the Contractor. The log shall identify the OHP Member and the following additional information:

(1) For Grievances, the date of the Grievance, the nature of the Grievance, the disposition and date of disposition of the Grievance;

(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 Grievances 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 OHP Member. The Contractor shall retain documentation of Grievances and Appeals for the term of the OHP Demonstration Project plus two years to permit evaluation. This requirement survives the termination or expiration of the Contract.

c. The Contractor shall have written procedures for the review and analysis of the Grievance System, including all Grievances 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 Grievances and Appeals shall include, at minimum, review of completeness, accuracy, timeliness of documentation, and compliance with written procedures for receipt, disposition, and documentation of Grievances and Appeals, and compliance with Oregon Health Plan rules.

Schedule 1 – Client Process Monitoring System (CPMS)

The Client Process Monitoring System (CPMS) tracks community-based treatment services for persons with mental illness, persons with developmental disabilities, and persons with substance abuse problems. Information from this system is combined with other information from other systems to create one integrated database under a single unique client identifier. The integrated database contains Consumer specific data across programs statewide and provides a Continuity of Care picture for individual Consumers. This information allows AMH to manage publicly funded mental health services, respond to legislative inquiries, and demonstrate cost effectiveness under the federal requirement for the OHP Medicaid Demonstration Project and State Children's Health Program.

1. General Provisions:

a. Contractor shall submit CPMS data for all OHP Members receiving Covered Services (except for acute inpatient hospital services which shall be reported on OP/RCS).

b. Contractor shall submit CPMS data for any OHP Member who is civilly committed to the custody of DHS under ORS 426.130.

c. AMH will process all CPMS data through the Mental Health Information System (MHIS). AMH will "pend" CPMS data that cannot be processed because of missing or erroneous date.

(1) AMH will notify Contractor monthly of all pended CPMS data.

(2) Contractor shall correct pended CPMS data within 30 calendar days of notice.

d. Timeliness

(1) Contractor shall work with AMH Data Base Analyst in developing, formatting and testing the CPMS to ensure reporting of accurate data.

(2) Contractor shall submit CPMS data to AMH for those OHP Members meeting the criteria described in this Section 1, within the time frames specified below in Section 2, Subsection b.

e. Data Transmission and Format:

(1) Contractor shall submit all CPMS data to AMH via electronic media in the specific CPMS format. Contractor may obtain reporting protocols upon request through the AMH Data Base Analyst.

(2) Contractor may request electronic access to the MHIS for Utilization monitoring purposes.

2. Data Set Requirements

a. Contractor shall submit all of the data specified in this section for OHP Members meeting the criteria described above in Section 1, and may develop a database to collect and store data reported electronically to the CPMS.

b. Contractor shall submit, within 30 calendar days of an OHP Member meeting the criteria described above in Section 1, and within 30 calendar days of terminating current Treatment services for such an OHP Member, the following CPMS information.

Data Element	Treatment Begin	Treatment End	Reported Quarterly
Client County of Residence	X		
Clinic or Service Provider	X		
Date of Birth	X		
Diagnosis	X	X	
Education	X		
Employment Status	X		
Gender	X		
Level of Functioning	X	X	X
Living Arrangement	X		
MHIS Number	X		
Name, Birth	X		
Name, Full	X		
Plan or Contractor Identifier	X		
Presenting Dangers		X1	
Prime Number	X		
Provider or Clinic Case No.	X		
Race/Ethnicity	X		
Referred From	X		
Termination Referral		X	
Termination Type/Reason		X	

Data element to be reported upon end of Urgent/Emergency Service only.

Schedule 2.1 – Procedure for Long Term Psychiatric Care Determinations for OHP Members 18 to 64

Actor	Action
Contractor	**1.** Determines whether the situation of the OHP Member meets both of the following criteria: **a.** There is a need for either Intensive Psychiatric Rehabilitation or other Tertiary Treatment in a State Hospital or Extended Care Program, or Extended and Specialized Medication Adjustment (psychotropic) in a secure or otherwise highly supervised environment; and **b.** The OHP Member has received all Usual and Customary Treatment including, if Medically Appropriate, establishment of a Medication program and use of a Medication Override Procedure. **2.** If the situation of the OHP Member meets both criteria listed above in step 1, does the following with assistance from Acute Inpatient Hospital Psychiatric Care or Subacute Psychiatric Care or Other Inpatient Services staff: **a.** Contacts the AMH ECMU Screener at (503) 947-5546, during normal business hours (Monday through Friday, 8 a.m. to 5 p.m.). **b.** Completes a Request for LTPC Determination for Persons Age 18 to 64 (request form). **c.** Obtains the following documents: **(1)** Physician's history and physical; **(2)** Current Medications, dosages, and length of time on Medication; **(3)** Reports of other consultations; **(4)** Social histories; and **(5)** Current week's progress notes. **3.** Sends, by facsimile, the request form and supporting documents to the AMH ECMU Screener at (503)947-5542.
ECMU Screener	**4.** Within three working days of receiving a completed request form, does the following: **a.** Reviews the request form and documentation for compliance with criteria for LTPC with the following facilities:

Actor	Action
ECMU Screener (cont.)	**(1)** OSH, Portland Campus; **(2)** OSH, Salem Campus; **(3)** Eastern Oregon Psychiatric Center (EOPC); **(4)** Efficacious alternatives in the community. **b.** If necessary, visits the Acute Inpatient Hospital Psychiatric Care or Subacute Psychiatric Care or Other Inpatient Services facility to interview staff and the OMAP Member. **c.** Indicates findings, determination and transfer date, if applicable, on the request form. **d.** Discuss findings, determination and placement alternatives with the Contractor. **5.** Sends, by facsimile, the completed request form to Contractor. If the OHP Member is enrolled with Greater Oregon Behavioral Health, Inc. (GOBHI), also forwards a copy of the request form to DHS Seniors and People with Disabilities Program and the EOPC billings office.
Contractor	**6.** If the OHP Member is not found Appropriate for LTPC or found Appropriate for LTPC but on a date other than that specified in Exhibit B, Part II, Section 1, Subsection c, Paragraph (9) (c) (i) of this Agreement, does the following: **a.** Decides whether to accept decision of the ECMU Screener. **b.** If the decision is not accepted, then requests a clinical review within three working days of receiving notice of the LTPC determination. Sends a written request and documentation submitted in accordance with Step 2.c. of this Exhibit to AMH via facsimile at (503) 378-8467. **c.** If the decision is accepted, either provides Appropriate treatment or initiates transfer of the OHP Member to the Setting recommended as of the date specified.
AMH	**7.** If the Contractor requests a clinical review, sends, by facsimile, the request form and documentation submitted by the Contractor in accordance with Step 2.c. of this Exhibit to the Clinical Reviewer.
Clinical Reviewer	**8.** Does the following within three working days of receiving the clinical review packet: **a.** Reviews all documentation submitted by the Contractor in accordance with Step 2.c. of this Exhibit

Actor	Action
Clinical Reviewer (cont.)	**b.** Decides whether the OHP Member is Appropriate for LTPC. **c.** Determines the effective date of LTPC as specified in Exhibit B, Part II, Section 1, Subsection c, Paragraph (9) (c) of this Agreement, if applicable. **d.** Updates the request form. **e.** Notifies, by phone, the Contractor, AMH and the ECMU Screener of the determination. **f.** Sends, by facsimile, the completed request form to the Contractor, AMH and the ECMU Screener.
ECMU Screener	**9.** If the OHP Member is found Appropriate for LTPC, coordinates with the physician and admission staff the transfer to the Setting recommended as of the date specified.
AMH	**10.** If transfer to the LTPC Setting will not occur on the date the OHP Member is Appropriate for LTPC, DHS will assume payment responsibility for charges related to the Acute Inpatient Hospital Psychiatric or Other Inpatient Services stay from the effective date of LTPC until the OHP Member is discharged from such Setting.

Determination		
Patient's Name:		Prime No.:
☐ Approved	Referral Date:	Name of Clinical Decision Maker:
☐ Denied	Approval Date:	Date of Determination:
		Date Patient Admitted to State Hospital:

Criteria for Long Term Psychiatric Inpatient Care

☐ Primary DSM Diagnosis is severe psychiatric disorder
☐ Documented need for 24-hour hospital level medical supervision
☐ At least one of the following conditions is met:

- ☐ Need for extended (more than 21 days) regulation of Medications due to significant complications arising from severe side effects of Medications.
- ☐ Need for continued treatment with electroconvulsive therapy where an extended (more than 21 days) inpatient environment is indicated and the inappropriateness of a short-term or less restrictive treatment program is documented in the Clinical Record.
- ☐ Continued actual danger to self, others or property that is manifested by at least one of the following:
  - ☐ The OHP Member has continued to make suicide attempts or substantial (life-threatening) suicidal gestures or has expressed continuous and substantial suicidal planning or substantial ongoing threats.
  - ☐ The OHP Member has continued to show evidence of danger to others as demonstrated by continued violent acts to person or imminent plans to harm another person.
  - ☐ The OHP Member has continued to show evidence of severe inability to care for basic needs but has potential for significant improvement with treatment.
- ☐ Failure of intensive extended care services evidenced by documentation in the Clinical Record of:
  - ☐ An intensification of symptoms and/or behavior management problems beyond the capacity of the extended care service to manage within its programs; and
  - ☐ Multiple attempts to manage symptom intensification or behavior management problems within the local Acute Inpatient Hospital Psychiatric Care unit.

Outcome of Clinical Review		
☐ Upheld	Transfer Date:	Name of Clinical Reviewer:
☐ Reversed		Date of Decision:

Request for Long Term Psychiatric Care Determination for Persons Ages 18 to 64

Request				
MHO:		Referral Date:		
OHP Member Name:				DOB:
Prime No (Required):		DSM Axis I	DSM Axis II	DSM Axis III
Admission Date:	Proposed Transfer Date:			

Basis for Request (NOTE: All documents must be attached.)

- ☐ There is a need for either:
- ☐ Intensive Psychiatric Rehabilitation or other Tertiary Treatment in an State Hospital or Extended Care Program, or
- ☐ Extended and Specialized Medication Adjustment (psychotropic) in a secure or otherwise highly supervised environment; and
- ☐ The OHP Member has received all Usual and Customary Treatment including, if Medically Appropriate, establishment of a Medication program and use of a Medication Override Procedure.

Documentation Supporting Request (NOTE: All documents must be attached.)

- ☐ Physician's history and physical
- ☐ List of current Medications, dosages and length of time on Medication
- ☐ Reports of other Consultations
- ☐ Social histories
- ☐ Current week's progress notes

Analysis of Documentation Supporting Request

Update 10/02

Schedule 2.2 – Procedure for Long Term Psychiatric Care Determinations for OHP Members 17 and Under

Actor	Action
Contractor	**1.** If the length of stay might exceed Usual and Customary Treatment, consults with the following regarding a potential need for LTPC: **a.** For OHP Members age 17 and under, the AMH Child and Adolescent Mental Health Specialist; **2.** Determines whether the situation of the OHP Member meets the criteria listed in step 5.a. **3.** If the situation of the OHP Member meets such criteria, does the following with assistance from Acute Inpatient Hospital Psychiatric Care or Psychiatric Residential Treatment Services (PRTS) staff: **a.** For OHP Members age 17 and under, contacts the AMH Child and Adolescent Mental Health Specialist during normal business hours (Monday through Friday, 8 a.m. to 5 p.m.). **b.** Completes a Request for LTPC Determination for Persons Age 17 and Under which includes the following documentation: • The child or adolescent has been referred for ICTS, date and provider; • A copy of the current Service Coordination plan; • A current Child and Adolescent Service • Intensity Instrument (CASII) score. **c.** Obtains the following documents: **(1)** Face Sheet (from current medical record) **(2)** Physician's history and physical; **(3)** List of current Medications, dosages, and length of time on Medication; **(4)** Reports of other Consultations; **(5)** Current psychosocial assessment; **(6)** Current week's progress notes;

Actor	Action
Contractor (cont.)	**(7)** Current psychological assessment; if determined Medically Appropriate ; **(8)** Current psychiatric assessment; **(9)** Psychiatric care admission history; and **(10)** Completed consent for release of information from the most recent residential or PRTS facility in which the child resided. **4.** Sends, by facsimile, the request form and supporting documents to the AMH Child and Adolescent Mental health Specialist. **NOTE: Steps 5 through 11 are completed within seven working days of receiving a completed request form.**
AMH Representative	**5.** Does the following: **a.** Completes an initial screening to decide whether the Community Coordinating Committee (CCC) LTPC screening criteria is met. Such criteria includes the following: **(1)** The primary DSM Axis I Diagnosis is from the OHP Prioritized List of Health Services; **(2)** There is documented evidence that the child has not responded to all Usual and Customary Treatment in an Acute Inpatient Hospital Psychiatric Care Setting or PRTS level of care; and **(3)** There is documented evidence that the child's psychiatric symptoms have intensified beyond the capacity of the Acute Inpatient Hospital or PRTS level of care; or **(4)** In exceptional circumstances a child may be screened who is not currently in an Acute Care Hospital or current functioning and documentation of prior treatment and treatment oriented placements indicate placement into Acute Care of Psychiatric Residential Treatment will benefit the child; **(5)** There is a documented need for 24-hour hospital level medical supervision under the direction of a psychiatrist in order to effectively treat the primary Diagnosis; and **(6)** The current CASII score indicates a level of acuity that requires inpatient care.

Actor	Action
AMH Representative (cont.)	**b.** If necessary, visits the Acute Inpatient Hospital Psychiatric Care or PRTS facility to interview staff and the OHP Member. **c.** If CCC LTPC screening criteria is met, and allocates time to attend the CCC LTPC screening. **d.** If CCC LTPC screening criteria is not met, notifies Contractor and CCC Chairperson.
CCC Chairperson	**6.** Schedules a CCC LTPC screening in conjunction with either the AMH Representative. **7.** Collects and distributes documentation necessary for the CCC LTPC screening **8.** Invites the CCC LTPC screening persons who possess information needed to make the LTPC determination and develop the CCC Care Path Plan. Such persons may include Contractor, Family members of the OHP Member or legal guardian, and/or treatment providers.
CCC	**9.** Conducts the CCC LTPC screening. **a.** Determine whether admission criteria has been met. **b.** Identifies efficacious community placement alternatives. **c.** Discusses findings, alternatives and determination with the Contractor and the AMH Representative. **d.** Notes the final determination. **e.** If admission criteria are met, does the following: **(1)** Establishes an admission date and time; and **(2)** Develops a CCC Care Path Plan. **f.** If admission criteria are not met, determines an appropriate plan of care. **g.** Completes the CCC LTPC Determination for Persons Age 17 and Under form by indicating findings, determination and planned admission date, if applicable. **10.** If the OHP Member is found Appropriate for LTPC, sets the effective date of LTPC as specified in Exhibit B, Part II, Section 1, Subsection c, Paragraph (9) (c) (i) of this Agreement. Sends, by facsimile, the completed CCC LTPC Determination for Persons Age 17 and Under form to Contractor.

Actor	Action
Contractor	**11.** If the OHP Member is not found Appropriate for LTPC or found Appropriate on a date other than the date described in step 10, does the following: **a.** Decides whether to accept the decision. **b.** If the decision is not accepted, requests a clinical review within three working days of receiving notice of the screening decision. Sends a written request and documentation submitted in accordance with Step 3.c. of this Exhibit to AMH, Child and Adolescent Services Section via facsimile at (503) 378-8467 **c.** If the decision is accepted, either provides Appropriate Treatment or initiates transfer of the OHP Member to the Setting recommended as of the date specified.
AMH	**12.** If a clinical review is requested, send, by facsimile, the request form and documentation submitted by Contractor in accordance with Step 3.c. of this Exhibit to the Clinical Reviewer.
Clinical Reviewer	**13.** Does the following within five working days of receiving the clinical review packet: **a.** Reviews all forms and documentation submitted by Contractor in accordance with Step 3.c. of this Exhibit. **b.** Decides whether the OHP Member is Appropriate for LTPC. **c.** Determines the effective date of LTPC as specified in V.B.3.i.(3)(a) of this Agreement, if applicable. **d.** Updates the CCC LTPC Determination form. **e.** Notifies by phone, Contractor and AMH Representative of the determination. **f.** Sends, by facsimile, the completed CCC LTPC Determination form to Contractor and the AMH Representative.
AMH	**14.** If transfer to LTPC will not occur on the date the OHP Member is Appropriate for LTPC, DHS assumes payment responsibility for charges related to the Acute Inpatient Hospital Psychiatric stay from the effective date of LTPC until the OHP Member is discharged from such Setting.

Request for Long Term Psychiatric Care Determination for Persons Age 17 and Under

REQUEST	
Child's Name:	Referral Date:
Parent/Guardian:	
Address:	Phone:
City:	County:
Child's Medicaid Prime No:	Child's SS#:
MHO:	DOB:
Current Program:	Admission Date:

DOCUMENTATION SUPPORTING REQUEST:	
Referral for ICTS, provider and date of referral	Code:
A copy of the current Service Coordination plan	Code:
A recent Child and Adolescent Service Intensity Instrument (CASII) score	Code:

CLINICAL DOCUMENTS:

- ☐ Physician history and physical
- ☐ List of current Medications, dosages, and length of time on Medication
- ☐ Reports of other consultations
- ☐ Current psychosocial assessment
- ☐ Current week's progress notes
- ☐ Current psychological assessment (if Medically Appropriate)
- ☐ Completed consent for release of information from the most recent residential or PRTS facility in which the child resided
- ☐ Current psychiatric assessment
- ☐ Psychiatric care admission history

SUMMARY OF REASONS FOR REQUEST

Long-Term Psychiatric Care Determination for Persons Age 17 and Under

Child's Name:

Mental Health Organization:

Name of AMH Representative:

Name of CCC Chairperson:

CRITERIA FOR LONG TERM PSYCHIATRIC INPATIENT CARE (NOTE: MUST MEET ALL CRITERIA.)

- ☐ Primary DSM Axis I Diagnosis is from the Prioritized List of Health Services
- ☐ Documented evidence that the child has not responded to all Usual and Customary Treatment in an Acute Inpatient Hospital Psychiatric Care or PRTS level of care Setting
- ☐ Documented evidence that the child's psychiatric symptoms have intensified beyond the capacity of the Acute Inpatient Hospital Psychiatric Care or PRTS level of care Setting
- ☐ Documented need of 24-hour hospital level medical supervision under the direction of a psychiatrist in order to effectively treat the primary Diagnosis
- ☐ Current CASII score indicates a level of acuity that requires secure inpatient psychiatric care

OUTCOME OF CCC CLINICAL SCREENING

Approved SCIP SAIP STS	Start of Care Date:	Name of Clinical Reviewer: Date of Decision:

Signature of AMH Representative:	Date:

Community Coordinating Committee
Care Path Plan

Child's Name:

Discharge Plan and Criteria

If LTPC admission criteria are met, include a written plan for discharge to the least restrictive appropriate Setting with specific discharge criteria linked to resolution of symptoms and behaviors that justified admission.

Services Recommended

If LTPC admission criteria are not met, describe services that are recommended.

Signature of CCC Chairperson Date:

Update 01-06

Schedule 2.3 – Procedure for Long Term Psychiatric Care Determinations for OHP Members Requiring Geropsychiatric Treatment

Actor	Action
Contractor	**1.** Determines whether the situation of the OHP Member meets both of the following criteria: **a.** There is a need for either Intensive Psychiatric Rehabilitation or other Tertiary Treatment in a State Hospital (or for adults Extended Care Program), or Extended and Specialized Medication Adjustment (psychotropic) in a secure or otherwise highly supervised environment; and **b.** The OHP Member has received all Usual and Customary Treatment including, if Medically Appropriate, establishment of a Medication program and use of a Medication Override Procedure. **2.** If the situation of the OHP Member meets both of the criteria listed in step 1, determines whether the OHP Member is eligible for OSH-GTS. To be eligible for these services, the DMAP Member must be: **a.** Age 65 or over, or **b.** Ages 18 to 64 and have significant nursing care needs (e.g., must be bathed, dressed, groomed, fed, and toileted by staff) due to an Axis III disorder of an enduring nature. **3.** With the assistance of Acute Inpatient Hospital Psychiatric Care or Subacute Psychiatric Care or Other Inpatient Services staff, does the following: **a.** Contacts the OSH Geropsychiatric Outreach and Consultation Service (OCS) at (503) 945-7136, Monday through Friday, 8:00 a.m. to 5:00 p.m.; **b.** Obtains the Request for Long-Term Care Determination for Persons Requiring Geropsychiatric Treatment (request form) from the OSH GTS staff; **c.** Assess OHP Member's capacity to provide informed consent. If OHP Member is determined unable to provide informed consent, take appropriate action towards Civil Commitment for OHP Members not already protected by guardianship. **d.** Obtains all supporting documents listed on the request form.

Actor	Action
	4. Sends, by facsimile, the request form and documents to the OSH Geropsychiatric OCS Screener at (503) 945-2807.
OCS Screener	**5.** Within three working days of receiving a completed request form, does the following: **a.** Reviews the request form and documentation for compliance with criteria for LTPC for persons requiring OSH-GTS. **b.** If necessary, visits the Acute Inpatient Hospital Psychiatric Care or Subacute Psychiatric Care or Other Inpatient Services facility to interview staff and the OHP Member. **c.** Discusses findings, determination, and placement alternatives with Contractor or Contractor Representative (i.e., the person who sent the request form or other person designated on the request form). **d.** Indicates findings, determination, and effective date of LTPC as specified in Exhibit B, Part II, Section 1, Subsection c, Paragraph (9) (c) (iii) of this Agreement on the request form. **6.** If the OHP Member is found Appropriate for LTPC at OSH-GTS, works with OSH-GTS, Contractor, and the Acute Inpatient Hospital Psychiatric Care or Subacute Psychiatric Care or Other Inpatient Services facility to set the OSH-GTS admission date and to coordinate such admission. **7.** Sends, by facsimile, the completed request form to Contractor and requester. Also, forwards a copy of the request form to the Institutional Revenue Section of DHS.
Contractor	**8.** If the OHP Member is not found Appropriate for LTPC at OSH-GTS, or is found Appropriate on a date other than the date specified in step 5.d., does one of the following: **a.** Accepts the decision of the OCS Screener and provides Appropriate Treatment. Works with Acute Inpatient Hospital Psychiatric Care or Subacute Psychiatric Care or Other Inpatient Services staff, Senior and Disabled Services DHS staff, and in some cases, Enhanced Care Services staff to develop a plan for continued care and Treatment.

Actor	Action
Contractor (cont.)	If the decision is not accepted, requests a clinical review within three working days of receiving notice of the LTPC determination. Sends a written request and documentation specified in Step 3.d. of this Exhibit to the AMH via facsimile at (503) 378-8467.
AMH	**9.** If Contractor requests a clinical review, sends, by facsimile, the request form and documentation submitted by Contractor in accordance with Step 3.d. of this Exhibit to the Clinical Reviewer.
Clinical Reviewer	**10.** Does the following within three working days of receiving the clinical review packet: **a.** Reviews all documentation submitted by Contractor in accordance with Step 3.d. of this Exhibit. **b.** Decides whether the OHP Member is Appropriate for LTPC. **c.** Determines the effective date of LTPC as specified in Exhibit B, Part II, Section 1, Subsection c, Paragraph (9) (c) of this Agreement, if applicable. **d.** Updates the request form. **e.** Notifies by phone: Contractor, AMH and the OCS Screener of the determination. **f.** Sends, by facsimile, the completed request form to Contractor, AMH and the OCS Screener.
OCS Screener	**11.** If the OHP Member is found Appropriate for LTPC, coordinates with the physician and admission staff the transfer to the Setting recommended as of the date specified.
AMH	**12.** If transfer to the LTPC Setting will not occur on the effective date of LTPC, DHS assumes payment responsibility for charges related to the Acute Inpatient Hospital Psychiatric or Other Inpatient Services stay from the effective date of LTPC until the OHP Member is discharged from such Setting

Request for Long-Term PsychiatricCare Determination for Persons Requiring Geropsychiatric Treatment

REQUEST				
MHO:			Referral Date:	
OHP Member Name:				DOB:
Referral Agent:		DSM Axis I	DSM Axis II	DSM Axis III
Admission Date:	Prime Number:			

BASIS FOR REQUEST (NOTE: All criteria must be met.)

☐ OHP Member is 65 or older or OHP Member is 64 or younger AND has significant nursing care needs (e.g., must be fed, dressed, groomed, bathed, and toileted by staff) AND these needs arise from an Axis III disorder of an enduring nature (e.g., Alzheimer's, Huntington's, TBI, CVA) (Note: A person 64 or under whose nursing care needs arise from acute decompensation of an Axis I disorder or are the result of behavioral noncompliance would not be admitted to GTS and should be referred to ECMU.)

☐ There is a need for either:

- ☐ Intensive Psychiatric Rehabilitation or other Tertiary Treatment in an State Hospital or Extended Care Program, or
- ☐ Extended and Specialized Medication Adjustment (psychotropic) in a secure or otherwise highly supervised environment; and
- ☐ The OHP Member has received all Usual and Customary Treatment, including if Medically Appropriate, establishment of a Medication program and use of a Medication Override Procedure.

DOCUMENTATION SUPPORTING REQUEST
(NOTE: All documents must be attached and must document the basis for request criteria.)

☐ Physician's history and physical	☐ Diagnostic Test results and Lab reports
☐ List of current Medications, dosages and length of time on Medication	☐ Guardianship or Civil Commitment documents (if applicable)
☐ Reports of other Consultations	☐ Civil Commitment investigation report (if available)
☐ Social histories	☐ ADL Assessment (if available)
☐ Current week's progress notes	☐ Advance Directive (if available)

Please summarize the reason why the patient needs LTPC.

ANALYSIS OF DOCUMENTATION SUPPORTING REQUEST
(Remainder of form to be completed by Gero Outreach staff.)

DETERMINATION

Patient's Name:		Prime No.:
☐ Approved ☐ Denied	Date of Determination:	Name of Clinical Decision Maker: Date Patient Admitted to OSH-GTS:

CRITERIA FOR LONG TERM GEROPSYCHIATRIC INPATIENT CARE

☐ Person is 65 or older or person is 64 or under and meets nursing care criteria.

☐ Person has a psychiatric/neurological disorder causing severe behavioral disturbances with need for 24 hour hospital level medical supervision.

☐ At least one of the following conditions is met:

- ☐ Need for extended (more than 21 days) regulation of Medications due to significant complications arising from severe side effects of Medications.
- ☐ Need for continued Treatment with electroconvulsive therapy where an extended (more than 21 days) inpatient environment is indicated and the inappropriateness of a short-term or less restrictive treatment program is documented in the Clinical Record.

☐ Continued actual danger to self, others or property that is manifested by at least one of the following:

☐ The OHP Member has continued to make suicide attempts or substantial life-threatening behavior or has expressed continuous and substantial suicidal planning or substantial ongoing threats.

☐ The OHP Member has continued to show evidence of danger to others as demonstrated by continued destructive acts to person or imminent plans to harm another person.

☐ For OHP Members 65 and over ONLY: The OHP Member has continued to show evidence of severe inability to care for basic needs due to significant decompensation of an Axis I Diagnosis.

☐ Failure of intensive Enhanced Care Services evidenced by documentation in the Clinical Record of:

☐ An intensification of symptoms and/or behavior management problems beyond the capacity of the Enhanced Care Service to manage within its programs; and

☐ A minimum of one attempt to manage symptom intensification or behavior management problems within the local Acute Inpatient Hospital Psychiatric Care unit.

☐ Has received all Usual and Customary Treatment including, if Medically Appropriate, establishment of a Medication program and use of a Medication Override Procedure. Has received medical evaluation and stabilization of acute medical problems.

OUTCOME OF CLINICAL REVIEW

☐ Upheld ☐ Reversed	Transfer Date:	Name of Clinical Reviewer: Date of Decision:

Update 10/02

Schedule 3 – Oregon Patient/Resident Care System

The Oregon Patient/Resident Care System (OP/RCS) contains information on all Consumers served at any of the state psychiatric hospitals, developmental disability training centers and psychiatric Acute Care facilities.

1. Contractor shall cooperate with AMH in establishing the electronic means to enter OP/RCS data at the hospital or facility providing Acute Inpatient Hospital Psychiatric Care Services under this Agreement.

a. Contractor shall provide AMH with a list of hospitals to be used in delivering Acute Inpatient Hospital Psychiatric Care.

b. Contractor shall identify the name, title and phone number of the person within each hospital with whom AMH will work to establish the computer hook-up to OP/RCS.

c. Contractor shall identify the names, titles and phone numbers of persons within each hospital with whom AMH will work to maintain the accuracy, timeliness and completeness of OP/RCS data submission.

d. Contractor shall work with AMH and hospital contact person in designating a physically secure (locked doors and limited access) location (floor and room number within hospital) of the stand alone computer to be used to enter OP/RCS data.

e. Contractor shall assure that hospital contact persons comply with confidentiality requirements contained in 45 CFR Parts 160 and 164, Subparts A and E, to the extent that they are applicable, and consistent with other state law or federal regulations governing privacy and confidentiality of mental health information, sign the request for access/assurance of confidentiality form, and return the form to AMH.

2. Contractor or its Subcontractors shall electronically submit, within 12 hours of admission to Acute Inpatient Hospital Psychiatric Care, OP/RCS information for Acute Inpatient Hospital Psychiatric Care Services provided to OHP Members as indicated in the following table.

Data Element	Admission	Discharge
Commitment Type Code[5]	X	
County of Residence	X	
County of Responsibility	X	
County of Discharge		X
County of Commitment	X	
Date of Commitment	X	
Date of Admission/Discharge	X	X
Date of Diagnosis		X
Date of Birth	X	
Discharge Reason Code		X
Driving Status		X
DSM, Axis V Diagnoses		X
DSM, Axis IV Diagnoses		X
DSM, Axis I Diagnoses	X	X
DSM, Axis III Diagnoses	X	X
DSM, Axis II Diagnoses	X	X
Education Level Achieved	X	
Ethnic Category Code	X	

[5]The Commitment Type Code is changed/updated as applicable.

Data Element	Admission	Discharge
Living Arrangement Code	X	X
Marital Status Code	X	
Name	X	
Name, Alias	X	
Oregon Driver's License Number	X	
ORS Reference Numbers	X	
Patient Number	X	
Referral Source Code	X	X
Sex	X	
Social Security Number	X	
Status of Harm to Property	X	
Status of Harm to Others	X	
Status of Suicide	X	
Status of Harm to Self (Non-Suicide)	X	
Time of Admission/Discharge	X	X
Time of Commitment	X	

Schedule 4 – Level of Need Determination Data

□ 1st Quarter (Jan-Mar) □ 2nd Quarter (Apr-Jun)
□ 3rd Quarter (Jul-Sep) □ 4th Quarter (Oct-Dec)

Contractor shall collect and analyze data obtained using the Child and Adolescent Service Intensity Instrument (CASII) for each OHP Member referred to the Integrated Service Array level of need determination process. Contractor shall submit a report to AMH, within 60 calendar days after the end of each calendar quarter, on a computer diskette clearly labeled Schedule 4, using the AMH specified data format or other AMH approved submission format as outlined in the Level of Need Data Validation Process document. For children, ages 6-17, Schedule 4, fields 1-23, shall be completed as required in the Exhibit instructions.

Because the Child and Adolescent Service Intensity Instrument (CASII) is not administered to children under age six, Schedule 4 fields 12-20, shall be completed using a zero in each field in lieu of the requested information designated in the exhibit instructions.

Contractor shall submit the following information in a text format, such as an ASCII string, with each field separated by a comma.

1. Last Name: OHP Member's Last Name
2. First Name: OHP Member's First Name
3. Middle Initial: OHP Member's Middle Initial
4. Date of Birth: OHP Member's Date of Birth (MM/DD/YYYY)
5. Gender: OHP Member's Gender (M/F)
6. Prime Number: OHP Member's Medicaid Recipient Identification Number
7. Date of Referral: The date the OHP Member was referred to determination process for Integrated Service Array (MM/DD/YYYY)
8. Referral Source: Originator of the referral, allowable codes include MH (mental health), ED (education), CW (child welfare), JJ (juvenile justice), PT (parent), or OT (other).
9. Date of Determination: The date OHP Member was assessed for level of need (MM/DD/YYYY)
10. CMHP ID: For all OHP Members enter 00
11. MHO Provider Number: Use 6 digit Medicaid Provider Number for MHO
12. CASII Domain I: (1-5)
13. CASII Domain II: (1-5)
14. CASII Domain III: (1-5)
15. CASII Domain IV-A: (1-5)
16. CASII Domain IV-B: (1-5)
17. CASII Domain V: (1-5)
18. CASII Domain VI-A: (1-5)
19. CASII Domain VI-B: (1-5)
20. Composite CASII Score: (Sum of Domains I-V)+(Greater of Domain VI-A or VI-B)
21. Determined ISA? (Y=Yes; N=No)
22. Level of Care Recommended: (1-6 [6])
23. Last day child is considered ISA eligible.

Contractor shall send this report to AMH, Medicaid Policy Unit, 500 Summer Street NE, E-86, Salem, Oregon 97301-1118.

6 Level 1: Recovery Maintenance and Health Management; Level 2: Outpatient Services; Level 3: Intensive Outpatient Services; Level 4: Intensive Integrated Service Without 24-Hour Psychiatric Monitoring; Level 5: Non-Secure, 24-Hour, Services With Psychiatric Monitoring; Level 6: Secure, 24-Hour, Services With Psychiatric Management. (Levels drawn from the CASII User's Manual, April 2004, Version 1)

Schedule 5 - Signature Authorization Form

Contracted Plan _____
OHP Assigned Plan Number: _____

Contractually required reporting information submitted to AMH must be certified by one of the following:

Chief Executive Officer (CEO),
Chief Financial Officer (CFO),
Contractor or
An individual who has delegated authority to sign for and reports directly to the CEO, CFO or Contractor.

This form is due upon effective date of this Agreement and immediately upon changes of the following forms:

* Grievance Systems, including Member Grievance and Appeal Form and Notice of Denial Letter,
* Third Party Resources and Personal Injury Lien Policy and Procedures,
* Utilization Management Policies and Procedures,
* OHP Member Information Materials, including Member Handbook and Annual Notification to OHP Members Regarding Ability to Participate in Activities of Contractor,
* Objections to Services Based on Moral or Religious Grounds,
* Policy and Procedure: CASII Administration,
* Policy and Procedure for Level of Need Determination, and
* Policy and Procedure for Prevention and Detection of Fraud and Abuse.

Print name and title of CEO/CFO/Contractor: _____
Signature: _____
Date: _____

As CEO/CFO/Contractor I authorize the following designated person(s) to certify AMH contractually required reporting:

Full name and title of the person(s) other than the CEO, CFO or Contractor identified above who has delegated authority to sign for and who reports directly to the CEO, CFO or Contractor and to certify the data and information submitted to DHS:

_____	_____
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 Contractually Required Reporting Form).

Schedule 5.1 - Attestation of MHO Revision and Submission of Contractually Required Reporting

I, an authorized official of Contractor, certify that the contractually required reporting itemized below have been reviewed for compliance and content for this Agreement period. In so certifying, Contractor is certifying that the documents in question below have experienced no further revisions from the last submission to and approval by AMH.

Signature _____

Document	Date of Original review and approval by AMH	Current Contract Year	No Revisions Made - Authorized Signatory	Notes
Grievance Systems				
Notice of Action (Boilerplate)				
Hearing Rights (Boilerplate)				
Third Party Resource/Personal Injury Line P&P				
Utilization Management P&P				
OHP Member Information Materials				
Plan Member Handbook				
Please specify type of document, eg. Brochure, etc.				
Objections to Services Based on Moral or Religious Grounds				
CASII Administration P&P				
Level of Need Determination P&P				
Policy and Procedure for Prevention/Detection of Fraud and Abuse				

Schedule 6 – Key Personnel

Contractor shall submit to AMH, within 30 days following the effective date of this Agreement and immediately following any changes. Information shall include names and contact numbers of the following key personnel: CEO/CFO/Contractor, Director/Manager, Medical Director (if applicable), Operations Manager (if applicable), Contract Liaison, Quality Assurance/Quality Improvement Liaison, Children's Coordinator, Grievance Systems Liaison, Long Term Psychiatric Care Liaison and Other.

<table>
<tr><th colspan="4">Mental Health Organizations</th><th colspan="3">MHO Contact Persons</th></tr>
<tr><td colspan="4">MHO
Address (Mailing and Location, if different)
Telephone Number
Fax Number
Plan Email address (if applicable)
Fiscal Year:</td><td>CEO/CFO/Contractor

Director/Manager</td><td>Contract Liaison</td><td>Children's Coordinator

Grievance Systems Liaison</td></tr>
<tr><td>Service Area (County)</td><td>Plan No. (M#)</td><td>Client Access Phone No.</td><td>ITT/TTY/Oregon Access No.</td><td>Operations Manager, (if applicable)

Medical Director, (if applicable)</td><td>Quality Assurance/Quality Improvement Liaison</td><td>Long Term Psychiatric Care Liaison

Other, (if applicable)</td></tr>
</table>