PART II

STATEMENT OF WORK,
TERMS AND CONDITIONS

I. Term and Approval

This Agreement shall become effective January 1, 2007 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, 2007. No work may be performed under this Agreement prior to its effective date.

If DHS wishes to amend this Agreement to extend its effectiveness beyond its current expiration date, DHS shall 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. Interpretation and Administration of Agreement

A. DHS may adopt reasonable and lawful policies, procedures, rules and interpretations to promote orderly and efficient administration of this Agreement. In interpreting this Agreement, its terms and conditions shall be construed as much as possible to be complementary, giving preference to Parts I and II of the Agreement over any exhibits or attachments. In the event that DHS needs to look outside of this Agreement, exhibits, and attachments for purposes of interpreting its terms, DHS shall 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's 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 AMH Supervising Representative with a postmark within 30 calendar days of the effective date or announcement date, whichever is last, of DHS's 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, AMH 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 AMH 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.

III. Administrative Rules and Applicable Law

Contractor shall comply with all federal, state and local laws, rules and regulations applicable to the work performed under this Agreement, including, but not limited to, all applicable federal and state civil rights and rehabilitation statutes, rules and regulations. Without limiting the generality of the foregoing sentence, Contractor shall comply with all duly promulgated DHS Rules in OAR chapter 309, made applicable by this Agreement, and applicable DHS Rules in OAR Chapter 410 whether in effect at the time this Agreement is signed or adopted or amended during the term of this Agreement. This includes those rules pertaining to the provision of prepaid capitated health care and Services, OAR Chapter 410, Division 141.

Contractor shall comply with OAR 410-120-1380, which establishes the requirements for compliance with Section 4751 of Omnibus Budget Reconciliation Act (OBRA) 1991 and ORS 127.649, Patient Self-Determination Act.

IV. 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 Children's Health Insurance Program. Enrollment is voluntary, except in the case of mandatory enrollment programs, pursuant to OAR 410-141-0060. DHS shall 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 Fully Capitated Health Plan (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 shall make available to Contractor Enrollment data files via an electronic bulletin board. Enrollment data files appearing on the bulletin board shall remain there until deleted and replaced with the most recent Enrollment data files resulting from the weekly or monthly Enrollment cutoff and compilations process. For the weekly Enrollment process, an Enrollment data file of new and disenrolled OHP Members shall appear on the electronic bulletin board Thursday morning of each week. For the monthly Enrollment process, Enrollment data files of new, closed and ongoing OHP Members for the next month shall appear on the electronic bulletin board three working 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.b. for the following reasons:

(1) 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 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 the 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.

(2) 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:

(1) is unruly or abusive to others;

(2) threatens or commits an act of physical violence

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

(4) is suspected of altering a prescription;

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

(6) otherwise misused the Medical Assistance Program;

(7) is under the jurisdiction of the Psychiatric Security Review Board (PSRB); or

(8) for other reasons specified in OAR 410-141-008.

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 Part II, Section VII, Consideration, Subsection E, 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.

V. Statement of Work

The Oregon Health Plan (OHP) has been restructured with the passage of House Bill 2519 which authorized application to the Center for Medicare and Medicaid Services (CMS) to amend and expand the current demonstration project under Section 1115 of the Social Security Act. 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.

A. Benefit Package

Contractor shall provide OHP Plus 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 fee-for-service. Contractor may cover, for OHP Members, Services that are in addition to those covered under the State plan.

1. 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.

2. 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.

3. 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 K, Definitions, Provider must meet criteria described in Part II, Section V, Statement of Work, Subsection N, Item 1.a.(2) Credentialing process.

4. Provision of Covered Services

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

   b. Contractor shall exclude or limit Covered Services in accordance with OAR 410-141-0500, Excluded Services and Limitations for Oregon Health Plan Clients.

   c. 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.

d. 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.

(1) 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.

(2) 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.

e. Contractor shall pay for Covered Services 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:

(1) 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.

(2) The OHP Member of the decision to deny payment as described in Exhibit G, Oregon Health Plan Mental Health Services Client Notices, Grievance, Appeals, and Hearings Process.

f. 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.

g. 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:

(1) 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;

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

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

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

h. 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.

i. 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 of Services not provided due to moral or religious

objections with its application for a Medicaid contract, within 30 days of start of Agreement, or whenever a policy is adopted during the period of the Agreement. Contractor shall notify OHP Members upon Enrollment and within 90 days after adopting the policy with respect to any particular Service.

5. 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:

a. Medical Transportation;

b. Medication;

c. Therapeutic Foster Care reimbursed under HCPC Code S5145 for OHP Members under 21 years of age;

d. Therapeutic Group Home reimbursed for OHP Members under 21 years of age;

e. Behavioral Rehabilitative Services that are financed through Medicaid and regulated by DHS Services to Children and Families and OYA;

f. Investigation of OHP Members for civil commitment;

g. Long Term Psychiatric Care as defined in Section V., B., 3., i., for OHP Members 21 years of age and older;

h. Preadmission Screening and Resident Review (PASRR) for OHP Members seeking admission to a Nursing Home;

i. Long Term Psychiatric for OHP Members age 17 and under;

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

(2) Secure Adolescent Inpatient Program (SAIP)

(3) Stabilization and Transition Services (STS)

j. 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 Long Term Psychiatric Care at an Oregon State Hospital;

k. Personal Care in Adult Foster Homes for OHP Members 21 years of age and older;

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

m. Services provided to persons while in the custody of a correctional facility or jail;

n. 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

o. Personal Care Services as described in OAR 411-34-0000 through 411-34-0090 and OAR 309-040-0300 through 309-040-0330.

6. 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 G, Oregon Health Plan Mental Health Services Client Notices, Grievance, Appeals, and Hearings Process. 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 Hearings.

7. 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.

8. Utilization Management

a. 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.

b. 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.

c. 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.

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

e. 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.

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

(2) 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.

(3) 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.

9. Authorization for Services

a. 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.

b. 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.

c. 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 G, Oregon Health Plan Mental Health Services Clients Notices, Grievances, Appeals and Hearings Process.

d. 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.

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

B. Delivery System Configuration

1. Needs Assessment

a. Contractor shall develop a mechanism for determining the Service demand and unique Service needs of its OHP Members based on, but not limited to, factors such as:

(1) Profiles of the Service Area such as: age, gender, ethnicity, and socio-economic indicators;

(2) Social indicators such as: unemployment rates, divorce rates, single parent household rate, homelessness rate, immigration, seasonal or transient residents, education levels, teenage pregnancy rate, and income and poverty levels; and

(3) Incidence of selected behaviors such as: attempted and completed suicide rates; rate of incarcerated persons with mental illnesses by type of crime; alcohol and drug usage (including arrests) by age, gender and ethnicity; alcohol and drug related deaths; alcohol and drug related motor vehicle accidents and fatalities; driving under the influence of intoxicants; reported domestic violence activity; child and elder Abuse investigations; nursing facility resident-to-resident abuse rates; diagnoses; school dropout rates; foster care density; and crime rates by type of crime, age, gender and ethnicity.

b. 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.

c. Contractor shall coordinate its needs assessment and Service delivery system planning effort with organized planning efforts carried out by the Local Mental Health Authorities of its Service Area.

2. Components of the Delivery System

a. Services Coordination

(1) 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.

(2) 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.

b. Preventive and Early Intervention Services

(1) 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.

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

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

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

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

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

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

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

c. Rehabilitative Treatment Services

(1) 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.

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

d. 24 Hour Urgent and Emergency Response System

(1) 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:

(a) 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.

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

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

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

(4) 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.

(5) 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.

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

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

(b) 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;

(c) 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.

(7) Contractor is financially responsible for Post-Stabilization Services that have not been pre-approved when:

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

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

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

(d) The OHP Member is discharged.

(8) 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.

(9) 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.

e. Involuntary Psychiatric Care

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

(2) 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.

(3) 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.

(4) 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.

(5) 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.

f. Acute Inpatient Hospital Psychiatric Care

(1) 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 Part II, Section V. Statement of Work, Subsection N, Credentialing Process, Item 1.b. and c.

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

(3) Contractor may request of AMH Extended Care Management Unit (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 Long Term Psychiatric Care 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 Long Term Psychiatric Care.

(4) 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 Oregon Youth Authority (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.

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

h. Integrated Services Array for Children and Adolescents

(1) The Integrated Services Array (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 Integrated Services Array 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.

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

(a) 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.

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

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

(3) 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.

(a) 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.

(b) 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:

(i) exceeding usual and customary services in an outpatient setting;

(ii) multiple agency involvement;

(iii) multiple out-of-home placements;

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

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

(vi) caregiver stress;

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

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

(c) 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.

(d) 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 Section V. B. 2.h

(e) OHP Members meeting the determination process outlined in Section V.B. 2. h (3) (b) 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.

(f) Contractor shall continue to provide Services consistent with access standards identified in Section V.D. 1 and V.D. 2 a-d for the time period between level of need determination and implementation of the service plan.

(g) 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 shall review the policies and procedures and notify Contractor of its determination within 30 days of receipt.

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

(4) 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.

(a) Community Care Coordination shall provide guidance and case management services in the planning, facilitating, and coordination of the child's Service coordination plan.

(b) A child and family team to assist in the development of the Service coordination plan may include the child, if appropriate, family members, child serving agencies involved with the child, school, and other community supports identified by the family.

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

(5) 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.

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

(a) the historical utilization of intensive treatment services, and

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

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

(a) 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.

(b) 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.

(8) 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 I, Section III.B. 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.

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

(a) 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.

(b) OHP Members meeting criteria for the ISA, as described in section V.B.2.h.(3), shall be served by a provider certified to provide intensive community based treatment services under OAR 309-032-1240 to 309-032-1305.

(c) 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.

(10) 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.

(11) Contractor shall ensure that all programs involved in the ISA meet the Credentialing Standards as outlined in Section V, Subsection N of the MHO Agreement and are licensed and certified by DHS under the Applicable Oregon Administrative Rules for the Program.

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

(a) 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.

(13) 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.

(14) Contractor shall be required to submit additional reports and information as identified by AMH for the purposes of quality assurance and monitoring 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.

(a) 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 quality assurance and monitoring 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.

(b) Contractor shall collect and analyze CASII data for quality assurance and quality improvement activities. Contractor shall submit to AMH, within 60 days of the end of each calendar quarter, a report consistent with Exhibit N, Level of Need Determination Data.

(c) Contractor shall develop a process for collecting and reporting data on outcome and performance measures in the following domains:

(i) School;

(ii) Home, life, and family;

(iii) Client functioning; and

(iv) Critical incidents.

(15) In addition to the utilization management requirements stated in Subsection V.A.8., 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.

3. 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.

a. 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 Section V. Statement of Work, Subsection A, Benefit Package, item 5, Mental Health Services Which Are Not Covered Services.

(1) 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.

(a) 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 I, Section III., B. of this Agreement.

(b) 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.

(c) 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.

b. 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.

c. 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.

d. 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).

(1) 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.

e. Physical Health Care Providers

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

(1) 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.

(2) 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.

(3) 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.

f. 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.

g. 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.

h. 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.

i. Long Term Psychiatric Care (LTPC)

(1) If Contractor believes an OHP Member is Appropriate for LTPC, Contractor shall request a LTPC determination from the applicable DHS program. DHS staff shall 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.

(a) 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 Extended Care Management Unit (ECMU) as described in Exhibit H.1., Procedure for Long Term Psychiatric Care Determinations for OHP Members Age 18-64;

(b) For OHP Members age 17 and under, the AMH Child and Adolescent Community Mental Health Specialist as described in Exhibit H.2., Procedure for Long Term Psychiatric Care Determinations for OHP Members age 17 and under; and

(c) 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 Oregon State Hospital Geropsychiatric Treatment Service (OSH-GTS), Outreach and Consultation Service (OCS) Team as described in Exhibit H.3, Procedure for Long Term Psychiatric Care Determinations for Persons Requiring Geropsychiatric Treatment.

(2) 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.

(3) DHS shall cover, the cost of LTPC of OHP Members determined Appropriate for such care beginning on the effective date specified below in Section V.B.3.i.(3) 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:

(a) The date ECMU receives a completed Request for Long Term Psychiatric Care Determination for Persons Age 18 to 64 form, or

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

(c) The date the OSH-GTS OCS Team receives a completed Request for Long Term Psychiatric Care Determination for Persons Requiring Geropsychiatric Treatment; or

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

(e) In cases where the Clinical Reviewer determines a date other than a date described above in Section V.B.3.i.(3)(a) through V.B.3.i.(c), 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 Section V.B.3.i.(3). The cost of the clinical review shall be divided equally between Contractor and AMH.

(4) Contractor shall:

(a) 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 Oregon State Hospital or Eastern Oregon Psychiatric Center.

(b) 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).

(c) 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.

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

(6) 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.

j. Consumer Involvement and Advocacy

(1) Contractor shall involve consumers, families, consumer advocates, and advocacy groups in planning, developing, implementing, operating and evaluating Services.

(2) Contractors' advisory bodies, such as Quality Improvement 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.

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

C. Delivery System Capacity

1. 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:

a. An appropriate range of services for the population enrolled or expected to be enrolled in Contractor's Service Area;

b. The expected utilization of Services, taking into consideration the characteristics and mental health care needs of OHP Members;

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

d. The number of Providers who are not accepting new OHP Members;

e. 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;

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

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

2. 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.

3. 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.

4. 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.

D. Accessibility and Continuity of Care

1. 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.

2. In addition to access and Continuity of Care standards specified in the rules cited above in Subsection D.1., Contractors shall establish standards for access to Covered Services and Continuity of Care which, at a minimum, include the following:

a. 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.

b. 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.

c. 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.

d. 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.

e. 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.

f. 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.

g. 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.

h. 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 D.1. Contractor shall provide this assessment no later than 60 days following the date of placement.

3. 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.

4. 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.

5. 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.

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

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

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

9. 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 Complaint and DHS Hearings processes.

10. 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.

11. 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.

    a. 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 assurance and utilization review standards.

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

    c. 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.

E. Quality Assurance/Quality Improvement (QA/QI) Requirements

1. QA/QI System

    a. Contractor and its Subcontractors shall have a planned, systematic and ongoing quality assessment and performance improvement process for monitoring, evaluating and improving the access, quality, and Appropriateness of Covered Services

provided to OHP Members including OHP Members with Special Health Care needs. The process shall include written policies, standards, and procedures that address the needs of OHP Members. Contractor shall have in effect, mechanisms to detect both underutilization and overutilization of services. If Contractor delegates any QA/QI activity, the process must state the extent of the delegation and how these activities are integrated in the overall QA/QI system.

b. Contractor's QA/QI Committee shall demonstrate evidence of stakeholder participation in the QA/QI program.

c. Stakeholder Input

Contractor shall have 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.

d. Contractor shall communicate to Providers the overall findings, including recommendations and opportunities for improvement, of data collected on performance and patient outcomes.

2. Quality Improvement Work Plan

Contractor shall develop and submit for approval to the Addiction and Mental Health Division (AMH) a written Quality Assurance/Quality Improvement (QA/QI) Work Plan within 45 days of the effective date of this Agreement. AMH shall review the QA/QI Work Plan and shall notify Contractor of its determination of approval within 30 days of receipt.

a. Contractor shall monitor progress in the domains of access to services; quality of services; integration and coordination of services; prevention, education and outreach; and clinical outcomes. Development of benchmarks and measurable objectives to monitor progress are required.

b. Contractor's QA/QI program must have on-going performance improvement projects (PIP) for the Covered Services it provides to Contractor's Members consistent with CFR 438.240 (b and d). Contractor shall conduct two (2) PIPs annually, one in a clinical and one in a non-clinical care area. PIP descriptions/overviews shall be submitted to AMH as part of the overall QA/QI work plan.

(1) Contractor is encouraged to collaborate with a Fully Capitated Health Plan and/or Dental Care Organization and/or Chemical Dependency Organization also serving Oregon Health Plan Members in Contractor's Service Area on an integrated PIP. As an alternative to a collaborative PIP, Contractor may propose another PIP to AMH, including current or on-going PIPs.

(2) In the event, that the Contractor chooses not to collaborate with a Fully Capitated Health Plan and/or Dental Care Organization and/or Chemical Dependency Organization, Contractor shall continue with existing PIP's or initiate a second PIP of the Contractor's choice.

(3) Contractor's PIPs must be designed to achieve measurable improvement sustained over time. These projects are expected to have a favorable effect on Member health outcomes and satisfaction. These projects shall contain the following elements:

(a) Measurement of performance using objective quality indicators;

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

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

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

(4) Contractor shall submit an annual summary of the findings from the QA/QI Work Plan, including the status and summary of findings of the PIPs from the previous year, 45 days after the termination of this Agreement (CFR 438.240). Contractor shall provide supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with AMH's standards for access to care (CFR 438.207(a)).

3. Member of AMH QA/QI Committee

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

F. Informational Materials and Education of OHP Members

1. 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:

a. Information about non-English language speaking Providers;

b. Restrictions of freedom of choice among Providers;

c. OHP Member rights and protections;

d. Covered Services;

e. Authorization requirements;

f. How to obtain Services from out of network providers;

g. After hours and emergency care;

h. Specialty care;

i. Cost sharing, if applicable;

j. How to access other services not covered by Contractor;

k. How to file a Grievance, Appeals and request a DHS Administrative Hearing;

l. How to request continuation of benefits pending the resolution of a Grievance, Appeal, or Hearing;

m. Advance directives;

n. Contractor's structure and operations; and

o. Practitioner Incentive Plans.

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.

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

a. Provide written information in each non-English language that is prevalent in Contractor’s Service Area;

b. Make oral interpretation Services available free of charge to each OHP Member and Potential enrollee, and inform OHP Members how to access those services;

c. Make written information available in alternate formats taking into consideration the special needs of OHP Members or Potential enrollees;

d. Notify OHP Members at least once a year of their right to request and obtain informational materials as described in this section.

3. 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.

4. 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.

5. 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:

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

   b. 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.

   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. Contractor shall inform adult OHP Members that complaints concerning noncompliance with the advance directive requirements may be filed with AMH.

G. OHP Member Rights

1. 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.

2. 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:

   a. The right to receive Covered Services;

   b. 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;

   c. 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;

   d. The right to participate in decisions regarding his or her health care, including the right to refuse Covered Services;

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

f. 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;

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

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

i. The right to refer oneself directly to Contractor for Covered Services without first having to gain authorization from another Provider;

j. The right to have access to Covered Services which at least equals access available to other persons served by Contractor;

k. 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 G, Oregon Health Plan Mental Health Services Client Notices, Grievance, Appeals, and Hearings Process;

l. The right to file Grievance or Appeal or request a hearing as described in Exhibit G, Oregon Health Plan Mental Health Services Client Notices, Grievance, Appeal, and Hearings Process;

m. The right to request an Expedited Hearing if the OHP Member feels the mental health problem is Urgent or emergent and cannot wait for the normal hearing process;

n. 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;

o. 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;

p. The right to have written materials explained in a manner which is understandable;

q. 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;

r. The right to be treated with respect and with due consideration for his or her dignity and privacy;

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

t. 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.

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

H. Grievances and Appeals

1. Contractor shall have a Grievance system which includes a Grievance process, an Appeal process and access to the administrative hearings process, consistent with Exhibit G, Oregon Health Plan Mental Health Services Client Notices, Grievances, Appeals and Hearings Process. Any grievance system requirements apply to all three components of the grievance system not just to the grievance process. A grievance process is the procedure for addressing enrollee's grievances. A grievance is an enrollee's expression of dissatisfaction with any aspect of their care other than the appeal of actions (which is an appeal).

2. Contractor shall provide all OHP Members, Providers and Subcontractors information regarding the Contractor's Grievance, Appeal and Hearings Process and shall include the following information:

   a. The OHP Member's right to file grievances and appeals and the procedures and timeframes for filing;

   b. The OHP Member's right to a DHS administrative hearing, how to obtain a hearing, and representation rules at a hearing;

   c. How the OHP Member can receive assistance in filing a grievance, an appeal, or administrative hearing request;

   d. The toll-free numbers for OHP Members to file oral grievances and appeals;

   e. The OHP Member's right to request continuation of benefits during an appeal or administrative hearing filing if filed within the timeframes specified for filing and, if the Contractor's action is upheld in a hearing, the OHP Member may be liable for the cost of any continued benefits; and

   f. Provider appeal rights to challenge payment or authorization decisions made by Contractor.

2. Contractor shall submit to AMH for review and approval, on the effective date of this Agreement, written Grievance and Appeal policies and procedures for accepting, processing and responding to all Grievances and Appeals from Family members, Local and/or Regional Allied Agencies, and OHP Members. Contractor shall also submit at that time the Member Grievance and Appeal Form and Notice of Denial letter to AMH for review and approval.

3. Contractor shall include on its Grievance and Appeal form places for the OHP Member or OHP Member Representative to indicate a request for benefit continuation when a Notice of Action has been issued, a request for an expedited Grievance and Appeal process, and the reason for expedited request. The Grievance and Appeal form shall also provide notice that any benefits continued may have to be repaid by the OHP Member if the issue is resolved in favor of Contractor.

4. Contractor shall give OHP Members any reasonable assistance in completing forms and other procedural steps, not limited to providing interpreter services and toll-free numbers with TTY/TDD and interpreter capability.

I. 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 C, 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.

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

2. 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 Care as defined in section V.B.3.i of this Agreement..

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

   a. any debt or payment of claims due to Contractor's insolvency;

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

   c. 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

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

4. 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.

J. Recordkeeping

1. 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.

2. 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 three 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.

3. 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 the 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.

K. Reports

1. Participating Provider Listing and Capacity Report

Contractor shall submit to AMH, the Mental Health Services Practitioner Report, as described in Exhibit A, as follows:

a. At the time it enters into a contract with the State.

b. One calendar month following the effective date of this Agreement;

c. 14 days prior to the effective date of a significant change that would affect adequate Capacity and Services;

d. 30 days prior to the effective date of a change in Contractor's geographic Service Area; or

e. within 30 days of the effective date of enrollment of a new population.

2. Grievance Log

a. Contractor shall submit to AMH, within sixty (60) calendar days following the end of each calendar quarter, the Health Plan Grievance Log, included in Exhibit B.

b. Contractor shall work with AMH to establish a method to collect and analyze data concerning Grievances and develop a method for Contractors to integrate the information in a Quality Improvement process.

3. QA Reports

Contractor shall negotiate with AMH to identify and agree upon activities to be reported.

4. Financial and Utilization Reports

Contractor shall submit to AMH, monthly, quarterly and yearly financial reports specified in Exhibit C, Solvency Plan and Financial Reporting.

5. 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 an inducement to reduce or limit Medically Appropriate Covered Services provided to an OHP Member. Contractor shall submit to AMH information necessary to comply with Sections 4204 (a) and 4731 of OBRA of 1990 that concern Practitioner Incentive Plans, if applicable. Such information shall be provided using reports specified in Exhibit I, Practitioner Incentive Plans.

6. 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.

7. 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, Quality Assurance/Improvement Liaison, Grievance, Appeals and Hearing Liaison, and Long Term Psychiatric Care Liaison.

8. Contractor shall submit to AMH, within 60 days of the end of each calendar quarter, the Level of Need Determination Data Report, as described in Exhibit N.

L. Data Systems

1. Encounter Data

Contractor shall submit accurate and complete Encounter data to DHS pursuant to Exhibit D, Encounter Minimum Data Set Requirements. Contractor shall ensure that the data received from Providers is accurate and complete by:

a. verifying the accuracy and timeliness of reported data;

b. screening the data for completeness, logic, and consistency; and

c. collecting Service information in standardized formats to the extent feasible and appropriate.

Contractor shall use the most current DSM Multi-axial Classification System inclusive of Axes I, II and V.

2. Client Process Monitoring System

Contractor shall submit accurate, timely and complete Client Process Monitoring System (CPMS) data to AMH pursuant to Exhibit E.

3. Oregon Patient/Resident Care System

Contractor shall submit accurate, timely and complete Oregon Patient/Resident Care System (OP/RCS) data to AMH pursuant to Exhibit F.

4. Failure to Comply with Data Submission Requirements

Contractor's failure to submit data in accordance with Exhibits D through F shall be considered in noncompliance with the terms of this Agreement and shall be grounds for withholding Capitation Payments as specified in Part II, Section VII, Consideration, Subsection G, Remedies Short of Termination.

5. Other Systems

Contractor shall maintain a health information system that collects, analyzes, integrates, and reports data. 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.

M. Research, Evaluation and Monitoring

1. In addition to submission of data described in Part II, Section V, Statement of Work, Subsection L, 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 State Children's Health Insurance Program. 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, Part II,

Section V, Statement of Work, Subsection J, Recordkeeping and Section XXX, Agreement Compliance and Quality Assurance Monitoring.

2. 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.

3. 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 OHMAS 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.