Contract Review Sheet

Contract for Services **HE-3063-19 - Am12**

Title: **PacificSource Community Solutions**

Contractor's Name: **PacificSource Community Solutions**

Department: **Health and Human Services** Contact: **Lyndsie Schwarz**

Analyst: **Sandra Fixsen** Phone #: **(503) 584-4898**

Term - Date From: **January 1, 2020** Expires: **December 31, 2025**

Original Contract Amount: **$ 19,172,591.00** Previous Amendments Amount: **$ 69,000,000.00**

Current Amendment: **$ 26,000,000.00** New Contract Total: **$ 114,172,591.00** Amd% **495%**

Incoming Funds ☐ Federal Funds ☐ Reinstatement ☐ Retroactive ☑ Amendment greater than 25%

Source Selection Method: **Not Applicable (Incoming Funds)**

Description of Services or Grant Award

MCHHS is entering into a Participating Provider Agreement with PacificSource whom is acting by and through OHA HSD to implement and administer services under the Oregon Health Plan. The parties shall enter into this agreement to provide Covered Services to PacificSource Members under a Coordinated Care Organization Contract with OHA.

Amendment 12: Adds funds in the amount of $26,000,000.00. Updates Reimbursement Schedule - Risk/Incentive Model under section 2.0 Compensation; 2.1 Fee for Service Reimbursement, amends Section 5.4 MLR Reporting and, amends Youth Fidelity Wraparound Addendum.

Desired BOC Session Date: **3/26/2025** Contract should be in DocuSign by: **2/26/2025**

Agenda Planning Date **3/6/2025** Printed packets due in Finance: **3/4/2025**

Management Update **2/25/2025** BOC upload / Board Session email: **3/5/2025**

BOC Session Presenter(s) **Ryan Matthews** Code: **Y**

REQUIRED APPROVALS

DocuSigned by: E4592AF8CAA542C... 2/27/2025
Finance - Contracts Date

DocuSigned by: Lyndsie Schwarz B84A939FCD02459... 3/6/2025
Contract Specialist Date

Signed by: Scott Norris 60C98A6F708240B... 3/5/2025
Legal Counsel Date

DocuSigned by: Jan Fritz DC16351248DE4EC... 3/5/2025
Chief Administrative Officer Date

MARION COUNTY BOARD OF COMMISSIONERS

Board Session Agenda Review Form

Meeting date: March 26, 2025

Department: Health & Human Services

Title: PacificSource Community Solutions (HE-3063-19 Am12)

Management Update/Work Session Date: February 25, 2025 **Audio/Visual aids** ☐

Time Required: 10 mins **Contact:** Lyndsie Schwarz **Phone:** 503-584-4898

Requested Action:
Approval

Issue, Description & Background:
This is the MCHHS Participating Provider Agreement with PacificSource whom is acting by and through Oregon Health Authority (OHA) Health Services Division (HSD) to implement and administer services under the Oregon Health Plan. The parties shall enter into this agreement to provide Covered Services to PacificSource Members under a Coordinated Care Organization Contract with OHA.

Amendment 12: Adds funds in the amount of $26,000,000.00. Updates Reimbursement Schedule - Risk/Incentive Model under section 2.0 Compensation; 2.1 Fee for Service Reimbursement, amends Section 5.4 MLR Reporting and, amends Youth Fidelity Wraparound Addendum.

Financial Impacts:
N/A

Impacts to Department & External Agencies:
Health and Human Services anticipates no financial impact to other departments.

List of attachments:
PacificSource Community Solutions Participating Provider Agreement Amendment

Presenter:
Ryan Matthews

Department Head Signature:
DocuSigned by:
Ryan Matthews
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AMENDMENT TO

PacificSource / Marion County, a political subdivision of the State of Oregon

PARTICIPATING PROVIDER SERVICE AGREEMENT

Effective January 1, 2025, the PacificSource Participating Provider Service Agreement with Marion County, a political subdivision of the State of Oregon is amended as follows:

I. **Attachment A-2** dated effective 01/01/2024 shall be replaced with **Amended Attachment A-2** dated effective 01/01/2025.
II. **Youth Fidelity Wraparound Addendum** shall be added effective 01/01/2025**.**

Except for the changes described herein, the Participating Provider Service Agreement remains unchanged.

HEALTH PLAN:		**PROVIDER:**	
PACIFICSOURCE COMMUNITY SOLUTIONS		**MARION COUNTY, A POLITICAL SUBDIVISION OF THE STATE OF OREGON**	
By:		By: See County Signature Page	DocuSigned by: Ryan Matthews 7D28A787656E458... (Signature)
Name:	Peter McGarry	Name:	Ryan Matthews
Title:	Vice President – Provider Network	Title:	HHS Administrator
Date:		Date:	2/27/2025
Email:	ORContracting@pacificsource.com	Email:	RMatthews@co.marion.or.us

SIGNATURE PAGE FOR
PACIFICSOURCE COMMUNITY SOLUTIONS - HE-3063-19
between
MARION COUNTY and PACIFICSOURCE COMMUNITY SOLUTIONS

MARION COUNTY SIGNATURES
BOARD OF COMMISSIONERS:

Chair	Date
Commissioner	Date
Commissioner	Date
Authorized Signature: DocuSigned by: Ryan Matthews 7D28A787656F458...	2/27/2025
Department Director or designee	Date
Authorized Signature: DocuSigned by: Jan Fritz DC16351248DE4EC...	3/5/2025
Chief Administrative Officer	Date
Reviewed by Signature: Signed by: Scott Norris 60C98A6F708240B...	3/5/2025
Marion County Legal Counsel	Date
Reviewed by Signature: DocuSigned by: E4592AF8CAA542C...	2/27/2025
Marion County Contracts & Procurement	Date

Attachment A-2

Marion County, a political subdivision of the State of Oregon

January 1, 2025

Reimbursement Schedule – Risk/Incentive Model

Community Mental Health Program

1.0 RISK/INCENTIVE MODEL.

The Risk/Incentive model agreed upon by Health Plan and Provider shall contain the following:

(A) A risk/incentive model involving multiple community Health Care Budgets for populations of Members assigned to specific physical health primary care providers, derived from revenue allocated for the physical health and behavioral health care needs of Members, and a settlement for providers with budget-based aligned incentives as indicated in this Attachment A.

(B) Fee-for-service payment for professional services provided by Provider with a Claims Risk Withhold, in addition to program-based PMPM reimbursement where appropriate.

(C) For distinct OHP Member populations assigned to physical health primary care providers with risk/incentive models in their agreements with Health Plan. A risk/incentive model which features Revenue and Expenses for physical health and behavioral health professional and residential services under OHP and paid by the State of Oregon to Health Plan as a global capitation payment, and less revenue reductions pertaining to (i) Hepatitis C reconciliations (as reconciled with the State of Oregon if necessary), (ii) HRA adjustments, taxes, premium transfers and other OHA mandated premium reductions, and (iii) excluding Revenue and Expenses in the following categories:

- State of Oregon mandated spending/expenses on social determinants of health.
- “Dental Care” premium allocation and expenses until such time as this premium and expenses are added to risk model described here.
- “Non-Emergent Medical Transportation” premium allocation and expenses.
- CCO Quality Incentive Measure (“QIM”) withhold return from the State of Oregon received in the year of settlement, whose distribution methodology is excluded as determined by the CCO Health Council.
- Operating payments to the CCO Health Council, taxes, adjustments and premium transfers.

(D) Contract terms that are consistent with the Joint Management Agreement (JMA) and JMA budget signed between Health Plan and the CCO Health Council which specifies the rules, duties, obligation, limitations on Health Plan margin, "Health Services" allocations, and other obligations and expenses for Health Plan as a CCO.

(E) Metrics which specify the return of part or all of the Risk Withhold and Surplus which may result from health care expenses measured against the HCB.

2.0 COMPENSATION.

2.1 Fee For Service Reimbursement

SERVICE/PROCEDURE	MAXIMUM ALLOWABLE	PERFORMANCE WITHHOLD
Outpatient Mental Health Services: 90785, 90832-90834, 90836-90840, 90846-90847, 90849, 90853, 90882, 90887, H0004, H0032, T1023, T2010, T2011	132% of OHP Allowable[1, 2, 3]	10%
Outpatient Behavioral Health Assessments: 90791, 90792, 96130-96133, 96136, 96137, H0001, H0031, H2000	164% of OHP Allowable[1, 2, 3]	10%
Other Outpatient Substance Use Disorder Services: H0002, H0004 (HF or HG), H0005, H0006, H0020, H0022, H0033, T1006	132% of OHP Allowable[1, 2, 3]	10%
Evaluation and Management Services: 99202-99205, 99211-99215, 99354, 99355	164% of OHP Allowable[1, 2, 3]	10%
ABA Therapy Services	100% of OHP Allowable[1, 2, 3]	10%
THW Services: Consistent with PacificSource guidelines	100% of OHP Allowable[1, 2, 3]	10%
Laboratory, DME: Services listed in the OHP Medical-Dental Fee Schedule	100% of OHP Allowable[1, 2]	10%
Injectables, Vaccines, Immunizations: Services listed in the OHP Medical-Dental Fee Schedule	100% of Billed Charge	10%
Services and procedures not otherwise listed in this Attachment Services listed in the OHP Fee Schedules	100% of OHP Allowable[1,2,3]	10%
Services and procedures without an established unit value listed above: PacificSource Health Plans may establish such unit values for purposes of its Maximum Allowable rate determination.	PacificSource Community Solutions Default Fee Allowance[4]	10%

Note: Payment will be based upon the lesser of the billed amount or PacificSource negotiated rates in effect at the time of service or supplies are rendered or provided as specified above.

1. PacificSource will reimburse based on the rates published as of the date of adjudication.
2. Updates to the schedules noted above shall be updated in accordance with OHP.
3. OHP Behavioral Health Fee Schedule is primary, OHP Medical-Dental Fee Schedule is secondary.

4. PacificSource utilizes industry standard publications and rate methods to supplement codes not established by the above noted methodologies.

2.2 Program-Based Reimbursement

Reimbursement for the services and programs defined below will be calculated as a per-member per-month (PMPM) payment based on full CCO (not county-specific) membership eligible for behavioral health benefits. The PMPM payment will be made prospectively based on the rates listed below with retroactive reconciliation as described below completed by Health Plan based on quarterly Provider reports using Health Plan's reporting template.

Services and Programs	Unit of Measure	$ per Unit
Youth Fidelity Wraparound Program (inclusive of all services, including those sub-contracted)	Per-Member Per-Month	$1,170[1]

1. On or before the 5th of the month, Provider shall send an invoice to Health Plan for Children's Wraparound Care Coordination. The invoice must include members served in the previous month and include the following data:

- Member name
- Member date of birth
- Medicaid ID number

Services and Programs	Unit of Measure	$ per Unit	Actual Payment Per Unit or PMPM
Professional Supervision for Licensure	Per supervision Session (60/45/30 minute increments), paid quarterly	60 = $435.55 45 = $295.89 30 = $200.65	
Local Public Health Authority Services	Per member per month		$0.33
Local Mental Health Authority Services (i.e. residential care coordination, civil commitment, system coordination)	Per member per month		$0.17
Assertive Community Treatment	Per enrolled member per month	$2,383.00	
Community Support Services (CSS) Total	Per member per month		
Total Program Support			**$10.62**

Allocation of payment for Community Support Services			
Crisis			$2.50
Mobile Crisis			$0.71
Supported Employment-Education			$0.87
Early Psychosis including EASA			$0.87
SPMI Day Treatment			$1.01
Intensive Children's Services			$0.38
Her Place			$0.45
His Place			$0.45
Other CSS:			$2.88

Services and Programs	Description, Conditions, and Reporting
Youth Fidelity Wraparound Program	Condition: Fidelity to OHA model Reporting: Monthly enrollment and enrollee encounters. On or before the 5th of the month, Provider shall send an invoice to Health Plan. This invoice shall indicate members served in a previous month and include the following data: • Member name • Member date of birth • Member identification number Payment: Health Plan shall verify member eligibility and coverage, prorating the monthly rate should the member have not been eligible for services for the entire month. Provider will submit additional data elements as determined by Health Plan in order to verify the services rendered and member eligibility.
Professional Supervision for Licensure	Description: Registered Associate is defined as individual who has completed education requirements and registered with their respective licensing board as they complete clinical hours for licensure. To quality for payment, Registered Associates must be employed by Provider and have entered into a board-approved supervisory agreement with a Clinical Supervisor employed by a Provider. Reporting: Provider shall submit supervision log for supervision hours provided to Registered Associates on or before 15 days following quarter's end. Annually (on or before January 15th), provider will submit roster of Registered Associates that Provider staff had supervision agreements with in prior year. Provider will include the supervision agreement for each Registered Associate listed. Payment: Payment is calculated by estimating potential revenue lost due to Clinical Supervisor and Registered Associate not being able to bill for psychotherapy services during supervision time. Payment may be recouped if evidence of a supervision agreement between the Registered Associate and Clinical Supervisor is not provided.
Assertive Community Treatment (ACT)	Reporting: Monthly enrollment and enrollee encounters. Provider shall send an invoice to Health Plan n or before the 5th of the

Services and Programs	Description, Conditions, and Reporting
	month. This invoice shall indicate members served in a previous month and include the following data: • Member name • Member date of birth • Member identification number Payment: Health Plan shall verify member eligibility and coverage, prorating the monthly rate should the member have not been eligible for services for the entire month. Provider will submit additional data elements as determined by Health Plan in order to verify the services rendered and member eligibility.
Community Support Services (CSS) Total	Reporting: Actual expenditures, enrollment, performance, and outcomes. Payment: Allocation of Program Support payment across CSS may be recalculated during the third quarter of each calendar year based on Provider's prior fiscal year budget and actual financials.

The following codes will be encountered at 100% of OHP fee schedule but not paid because payment is included in the Services and Program payments detailed above:

Services and Programs	Codes
Youth Fidelity Wraparound	H2011, H2022
Fidelity Assertive Community Treatment	H0039
Day Treatment	H0036
Crisis	H2011, S9484, S9125
Early Psychosis including EASA	
Peer Support Services	
Supported Employment/Education	H2023
Intensive Children's Services	
Additional Community Support Services	G0176, G0177, H0034, H0046, H2010, H2018,H2027, H2032, H2033, H2021

2.3 Performance Withhold Return Contingent On Quality

One hundred percent (100%) of any Provider's Performance Withhold return will be paid contingent on the performance of the performance measures defined in this Attachment, some of which are established and measured by the State of Oregon for the entire CCO and will be awarded based on such State of Oregon measurement and State of Oregon final payment for the CCO.

3.0 SETTLEMENT PERAMETERS.

3.1 Settlement Parameters

The following settlement parameters for this section pertain for OHP members assigned to Provider.

3.2 Time Period.

Annual Performance Withhold settlement will occur for the calendar year in the month of August after the close of the contract period ending December 31st. Performance Withhold return will be made to Provider in the month of August after final OHA determinations of QIM revenue determinations.

3.3 Performance Withhold Settlement Summary.

Health Plan shall be responsible for computing, documenting, and reporting to Provider an annual Performance Withhold settlement summary. This report shall be submitted to Provider in the month of August after year-end.

3.4 Budget Surplus or Deficit

For the contract period for the experience of Members assigned to any physical health primary care provider with a risk/incentive model in their agreement with Health Plan, the Health Care Budget will be compared to actual expenses incurred to determine whether a Surplus or Deficit exists.

3.4.1 Value Based Payment.

Provider will cooperate with Health Plan in complying with OHA requirements for value-based payments in the areas of: Maternity, Hospital, Pediatric, Behavioral Health and Oral Health care. As such, Performance Withhold return may be contingent on a specific array of metrics pertaining to these OHA-required areas as determined by Health Plan and Provider.

3.4.2 Unearned Performance Withhold

Any Unearned Performance Withhold shall be allocated in the following order:

1st Used to contribute to Health Plan's limited margin, consistent with the limitation in the Joint Management Agreement (JMA) between Health Plan and the CCO Health Council.

2nd Any remaining Unearned Performance Withhold Payment will be treated as shared savings under the terms of the JMA.

4.0 PERFORMANCE MEASURES AND REPORTING.

4.1 Performance Measures

Any Performance Withhold Distribution to Provider shall be based on the below, with the weight of each performance measure representing the percentage of return to be paid based on achieving the measure.

4.2 Performance Reports

Performance measure reports from Provider shall be submitted using Health Plan's ShareFile site by 11:59pm on the due date stated. Late submissions will incur a 25% penalty on weighted performance withhold value per partial or full week that reporting is submitted after the due date.

5.0 GENERAL PROVISIONS.

5.1 Requirements

Provider will cooperate with Health Plan on Health Plan's CAHPS Improvement Plans.

Provider allow Health Plan to share individual provider performance with CCO Health Councils.

Provider will collaborate with Health Plan to gain consensus through the CCO Health Council on maximizing and distributing Quality Pool funds from OHA.

Provider will collaborate with Health Plan to comply with the OHA Health Plan Quality Metrics Committee (HPQMC), with Health HPlan responsible for describing quality metrics from the HPQMC that will be used.

Provider will collaborate with Health Plan to comply with OHA's Practitioner Incentive Plan (PIP) reporting.

Provider will cooperate with Health Plan to collaborate on fulfilling any OHA requirements in the increased adoption of Health Information Exchange (HIE), Health Information Technology (HIT), and Electronic Health Record (EHR) technology.

5.2 Oregon Health Plan/OHA Capitation Administration Regulations

In the event of (a) new or changing requirements, rules, regulations or guidance related to applicable provider capitation payments made by Health Plan to Provider, and per Health Plan Exhibit L filing and Medical Loss Ratio filings submitted to OHA, and/or (b) Health Plan's and/or OHA's interpretation of applicability of such requirements, rules, regulations, or guidance and applicability of Health Plan's capitation payment methodology with Provider, Health Plan may enact the following:

- A charge commensurate with any OHA recoupment, demand for repayment, charge, tax or fee, to be charged against the CCO Health Care Budget, and/or
- A renegotiation with Provider to revert all payment methodologies entailing Provider capitation, to a fee-for-service payment methodology.

Provider shall cooperate with Health Plan to produce reports for Health Plan and/or OHA that satisfy to Health Plan and OHA discretion, the requirements, rules, regulations or guidance from OHA related to capitation payments.

5.3 Oregon Health Plan/OHA Possible Premium Revision / MLR-based repayment to OHA

In the event of a revision of premium levels for OHP members by the State of Oregon/OHA by a net amount deemed by Health Plan to be inconsistent with the reimbursement agreed to in this 2020 Agreement, Health Plan will notify Provider of such inconsistency in writing, and both parties will enter into a renegotiation of 2020 reimbursement rates to achieve consistency with any new Oregon Health Plan/OHA premium levels.

In the event OHA determines Health Plan must pay OHA any sum because the CCO Medical Loss Ratio (MLR), as determined by OHA, does not meet a minimum threshold for the entire population or any benefit-category specific sub populations, PacificSource reserves the right to (a) deduct a pro-rata portion of such repayment from the Health Care Budget in Section 6, or (b) make direct investments to increase the MLR and offset such expenses with the settlement, upon communication with Provider and the CCO Health Council.

5.4 MLR Reporting.

Provider shall submit to Health Plan a report for each clinic for the cost year January 1 – December 31 no later than March 30 of the following cost year using a format accepted by OHA. Provider shall refer to "Medical Loss Ratio Rebate Instructions" (as published on the OHA CCO Contract Forms website at http://www.oregon.gov/oha/healthplan/Pages/cco-contract-forms.aspx) for support.

5.4.1 **Biannual Reporting**

Provider shall submit a biannual expense report to Health Plan's Share File system sixty (60) days after the end of each six (6) month period using a format provided by Health Plan. The biannual expense report includes encounterable and non-encounterable expenses for the services and programs defined in this Attachment.

5.5 Community Health Improvement Plan, Transformation Plan and Health Council Activities.

Provider will collaborate with Health Plan, the CCO Health Council, and other stakeholders in completing a Community Health Assessment (CHA) and a Community Health Improvement Plan (CHIP), and in carrying out activities to implement the CHIP including any recommendation tied to community access studies. Provider will collaborate with PacificSource, the CCO Health Council, and other stakeholders to carry out the Transformation And Quality Strategies. For purposes of the CHA, CHIP, or Transformation And Quality Strategies, for reporting to the CCO Health Council or any of its subcommittees, or for reporting to OHA, PacificSource may share Provider utilization, membership numbers, and additional performance data. Provider will collaborate with PacificSource and the CCO Health Council to meet Transformation And Quality Strategies requirements and participate in Transformation And Quality Strategy projects.

5.6 Value-Based Payment.

Provider agrees to participate in Health Plan's Value-Based Payment (VBP) program, consistent with OHA requirements in which an increasing portion of provider payment conforms to the Learning and Action Network (LAN) category 2C or higher, which may entail the following elements.

- Payment based on any of the above methodologies
- Payment Withhold
- Surplus sharing
- Payment models to support care transformation and quality improvement in the following areas:

Hospital Care
Maternity Care
Children's Care
Behavioral Health Care
Oral Health Care

In collaboration with Provider, PacificSource will share with Provider information pertaining to Health Information Technology (HIT) to support success in effective participation with the VBP program.

6.0 MISCELLANEOUS.

6.1 Defined Terms

Any terms not otherwise defined herein shall have the meaning set forth in the Participating Provider Agreement.

6.2 Precedence

Any conflict or inconsistency shall be resolved by giving precedence to this Attachment first then the Participating Provider Agreement.

ADDENDUM

Marion County, a political subdivision of the State of Oregon

01/01/2025

Youth Fidelity Wraparound

RECITALS

A. Wraparound is an intensive care coordination process for youth with emotional and behavioral disorders who are involved in multiple systems. These systems include, but are not limited to, mental health, addictions, child welfare, intellectual or developmental disabilities, juvenile justice, and education. Wraparound is a team-based, strengths-based process that organizes a youth-and-family-driven system of services and supports. Services and supports are individualized for a youth and family to achieve family and youth identified goals.

B. Provider is committed to participating in supporting the continuum of care that integrates health services by means of implementing a System of Care approach that includes models such as Wraparound for children with behavioral health disorders.

C. Provider serves as a Wraparound Provider or supports multiple Wraparound Providers, and Provider specializes in providing Wraparound supports to eligible Members in accordance with OAR 309-019-0162 & 309-019-0163. Provider delivers Wraparound supports pursuant to Fidelity Wraparound requirements, as required by OAR 309-019-0162 & 309-019-0163 and Exhibit M of the CCO Contract.

1. WRAPAROUND WORK.

Health Plan retains Provider to create, support, and manage the services for its Members in the Service Area as described and in accordance with this Section 1 (the "Wraparound Work"). Provider agrees to render all Wraparound Work in accordance with the terms and conditions of the Agreement and this Attachment, applicable state and federal law, applicable government regulations and guidance, and in conformity with appropriate and accepted standards of care for those services. Nothing herein is intended to create, and shall not create, any exclusive arrangement between Health Plan and Provider. This Agreement shall not restrict either Party from acquiring similar, equal or like goods or services from other entities or sources. The Parties acknowledge that there may be changes in OHA guidance or interpretation in the future that impact this Agreement. The Parties agree to work together to adjust and incorporate such OHA guidance and interpretations into this Agreement and/or into the work performed hereunder, as well as any new requirements from an amendment to the CCO Contract or as otherwise required by OHA. Provider shall perform Wraparound Work, as described in greater detail below:

1.1 Wraparound Services. Provider shall administer Wraparound care coordination services to Fidelity, consistent with the obligations specifically related to Wraparound services set forth in OAR 309-019-0163 and Exhibit M of the CCO Contract. In particular, Provider shall:

- Ensure certified providers administer the Child and Adolescent Needs and Strengths Assessment ("CANS") Oregon to members, consistent with the requirements set forth in Exhibit M of the CCO Contract, including input of CANS data into state data system. All staff administering the CANS must be certified by the Praed Foundation;
- Ensure its providers and staff have attended the Division-approved foundational Wraparound training within 90 days of the hire date, applicable to the role in the Wraparound care team.
- Ensure its providers and staff are trained in integration and foundations of Trauma Informed Care, recovery principles, motivational interviewing, assessing for Adverse Childhood Experiences, and rendering services in a Culturally and Linguistically Appropriate manner.
- Complete required documents for each enrolled youth and their family pursuant to the Fidelity model.
- Input member information into state's Fidelity and Monitoring System, WrapStat, or other Division-required data monitoring system, including: Medicaid ID numbers, Wraparound enrollments, discharges, and member demographic information.
- Distribute WFI-EZs according to the evaluation cycles identified in WrapStat, ensuring all youth and members of their Wraparound team who are a part of the evaluation cycle are provided the opportunity to complete a WFI-EZ. WFI-EZs can be collected electronically through WrapStat or in hard copy format, with all paper copies required to be submitted to Health Plan for entry into WrapStat.
- Complete TOMs during evaluation cycles identified in WrapStat.

1.2 **Clients Served.** Provider shall be reimbursed for the number of Wraparound clients served each month. Provider will be responsible for invoicing PacificSource on a monthly basis to indicate youth enrolled in Wraparound program.

1.3 **PacificSource's Wraparound Policies.** Provider agrees to comply with Health Plan's Wraparound policies and procedures, including those policies and procedures specifically related to Wraparound services described in Exhibit M of the CCO Contract. Provider also agrees to provide feedback not less than annually in order to support Health Plan in improving its policies and procedures to meet the needs of the local community.

1.4 **Wraparound Staff.** Provider will ensure the implementation of Fidelity Wraparound by hiring and training the following staff required in Exhibit M to deliver Wraparound Work:

- Wraparound Care Coordinator;
- Wraparound Supervisor;
- Wraparound Coach;
- Youth Peer Delivered Service Provider;
- Family Peer Delivered Service Provider; and

- Peer Delivered Service Provider Supervisor.

1.5 Workforce. On not less than a quarterly basis, Provider agrees to share with Health Plan a summary of its workforce, including whether any of its employed or contracted workforce are certified or grandfathered as traditional health workers, as well as their corresponding scope of practice using a THW reporting template supplied by Health Plan. This information is required by the OHA, and allows the Health Plan to develop targeted strategies to meet member health needs. After Provider produces this analysis, the Parties agree to meet and review the analysis to discuss barriers and opportunities.

1.6 Assistance in Meeting OHA Obligations. Provider agrees to cooperate with and assist PacificSource in fulfilling PacificSource's obligations to the OHA with regard to services performed under this Agreement. Notwithstanding the foregoing, nothing in this Attachment will require Provider to provide oral health or physical health interventions unless otherwise agreed to by the parties.

1.7 Behavioral Health Report. Provider agrees to collaborate with Health Plan to complete reporting to the OHA, including the Behavioral Health Report that Health Plan must submit to the OHA on an annual basis.

1.8 Wraparound Collaboration. Provider agrees to work collaboratively with Health Plan staff, as reasonably requested. Provider also agrees to participate in technical assistance offered by Health Plan, including training in trauma-informed care principles.

1.9 Participation in System of Care Governance. Provider agrees to participate in System of Care work groups, including the Practice Level Workgroup, to support a comprehensive, person-centered, individualized, and integrated community-based array of child and youth behavioral health services using System of Care principles.

1.10 Participation in Community Governance. Provider agrees to participate in the local Community Health Assessment and Community Health Improvement Plan, as may be requested by Health Plan from time to time. In addition, Provider agrees to participate in the Community Advisory Council to share valuable perspectives with the community.

1.11 Caseloads. Provider shall track the ratio of care coordinators, family support specialists, and youth support specialists to families served. Provider shall maintain adequate staffing in order to ensure that at no time the ratio of providers to families served exceeds 1:15. If at any time the ratio exceeds 1:15, Provider shall immediately notify Health Plan so that Health Plan may take appropriate next steps pursuant to Health Plan's policies and procedures.

1.12 Data Collection and Reporting. In order to support Provider and Health Plan's joint efforts to serve Members and in service of the OHA's requirements to collect data about the delivery of Wraparound services, Provider agrees to provide reporting to Health Plan that includes the following:

- Wraparound Annual Utilization Report (annually)

- Number of youth served (quarterly)
- Ratio of employed or contracted staff to total number of youth served (quarterly)
- Number of requests for Wraparound services and number enrolled in Wraparound, including explanations for those not enrolled (quarterly)
- Number of youth discharged from Wraparound (quarterly)
- Race/Ethnicity and Language of eligible members enrolled in and discharged from Wraparound (quarterly)

1.13 Reporting Penalties. Provider agrees to supply the reporting deliverables listed in Section 1.12. Provider agrees to indemnify and hold Health Plan harmless against any and all fines, fees, and/or assessments assessed by the Oregon Health Authority as a result of Provider's failure to timely meet the reporting deliverables identified in this Agreement.

1.14 Encounter Data. Provider agrees to submit claims for all Wraparound services provided by Wraparound staff, as identified in Section 1.4. All Wraparound services (excluding CANS assessments billed using H2000) shall be submitted and include the member's diagnosis or diagnoses, Procedure Code H2021, Community-based Wraparound Services, per 15 minutes, and the number of units per service (e.g., a 45 minute encounter would require claim submission of H2021 for 3 units). These claims are for encounter reporting purposes only and will not be reimbursed, per payment agreement in Attachment A.

1.15 Workforce Training. Provider shall ensure that all staff receive training as required in the Contract including, but not limited to, Cultural Responsiveness, Implicit Bias, CLAS Standards, Trauma Informed Care, and uses of data to advance health equity. Provider and provider staff may access trainings offered by the PacificSource Training Program. For all other training, Provider shall have mechanisms in place that enable reporting to Health Plan, at Health Plan's reasonable request, details of training activities, annual training plans, training subjects, content outlines, objectives, target audiences, delivery system, evaluations, training hours, training attendance, and trainer qualifications. At a minimum, Provider shall provide Health Plan with an Annual Training and Education Report so that Health Plan may compile such information into Health Plan's report to the OHA.

2. PAYMENT.

Provider shall be paid for providing the Wraparound Work pursuant to Attachment A of the Agreement.

3. TERM AND TERMINATION.

This Addendum shall be in full force and effect for the Term of the Agreement, unless earlier terminated as provided herein. Either Party may terminate this Addendum, without impacting the Agreement, with the other Party's written consent, which shall not be unreasonably withheld.

4. DATA USE.

The Parties recognize and agree that it may be necessary to share certain data with each other that was not anticipated to give this Addendum its full force and effect. The Parties

agree that they will meet and determine the exact data to provide, in accordance with the terms of this Addendum, as it becomes necessary. The additional specifications for that data may be added as an amendment, at any time, to this Addendum as mutually agreed to by the Parties. The Parties acknowledge that the CCO Contract requires significant reporting to OHA, including documentation establishing compliance with OAR 309-019-0163, and agree to work together to ensure the proper completion and filing of such reports so that Health Plan may fulfill its obligations under the CCO Contract. Provider acknowledges that OHA will post many of the reports on its website. Where redaction of certain information is allowed, the Parties will coordinate on the identification of those redactions, although Health Plan will have the right to make the final redactions based on its sole discretion.

PacificSource Community Solutions

AMENDMENT TO

PacificSource / Marion County, a political subdivision of the State of Oregon

PARTICIPATING PROVIDER SERVICE AGREEMENT

Effective January 1, 2024, the PacificSource Participating Provider Service Agreement with Marion County, a political subdivision of the State of Oregon is amended as follows:

I. **Attachment A-2** dated effective 01/01/2023 shall be replaced with **Amended Attachment A-2** dated effective 01/01/2024.

II. **Youth Fidelity Wraparound Addendum** shall be added effective 01/01/2024.

Except for the changes described herein, the Participating Provider Service Agreement remains unchanged.

HEALTH PLAN:

PACIFICSOURCE COMMUNITY SOLUTIONS

By: Peter McGarry

Name: Peter McGarry

Title: Vice President – Provider Network

Date: 3/19/2024

Email: ORContracting@pacificsource.com

PROVIDER:

MARION COUNTY, A POLITICAL SUBDIVISION OF THE STATE OF OREGON

By: DocuSigned by: Ryan Matthews 7D28A787656E458... (Signature)

Name: Ryan Matthews

Title: HHS Administrator

Date: 2/13/2024

Email: RMatthews@co.marion.or.us

SIGNATURE PAGE FOR
PACIFICSOURCE COMMUNITY SOLUTIONS - HE-3063-19 AMD #11
between
MARION COUNTY and PACIFICSOURCE COMMUNITY SOLUTIONS

MARION COUNTY SIGNATURES
BOARD OF COMMISSIONERS:

Chair — Date: 3.6.24

Not Present At Meeting

Commissioner — Date

Commissioner — Date: 3/6/2024

Authorized Signature: DocuSigned by: Ryan Matthews 7D28A787656F458... — Date: 2/13/2024
Department Director or designee

Authorized Signature: DocuSigned by: Jan Fritz 1E984034585E453... — Date: 2/14/2024
Chief Administrative Officer

Reviewed by Signature: DocuSigned by: Scott Norris 60C98A6F708240B... — Date: 2/14/2024
Marion County Legal Counsel

Reviewed by Signature: DocuSigned by: Jeff D White D1ECCAACCDB14CB... — Date: 2/13/2024
Marion County Contracts & Procurement

Attachment A-2

Marion County, a political subdivision of the State of Oregon

January 1, 2024

Reimbursement Schedule – Risk/Incentive Model

Behavioral Health Provider or Community Mental Health Program

1.0 RISK/INCENTIVE MODEL.

The Risk/Incentive model agreed upon by Health Plan and Provider shall contain the following:

(A) A risk/incentive model involving multiple community Health Care Budgets for populations of Members assigned to specific physical health primary care providers, derived from revenue allocated for the physical health and behavioral health care needs of Members, and a settlement for providers with budget-based aligned incentives as indicated in this Attachment A.

(B) Fee-for-service payment for professional services provided by Provider with a Claims Risk Withhold, in addition to program-based PMPM reimbursement where appropriate.

(C) For distinct OHP Member populations assigned to physical health primary care providers with risk/incentive models in their agreements with Health Plan. A risk/incentive model which features Revenue and Expenses for physical health and behavioral health professional and residential services under OHP and paid by the State of Oregon to Health Plan as a global capitation payment, and less revenue reductions pertaining to (i) Hepatitis C reconciliations (as reconciled with the State of Oregon if necessary), (ii) HRA adjustments, taxes, premium transfers and other OHA mandated premium reductions, and (iii) excluding Revenue and Expenses in the following categories:

- State of Oregon mandated spending/expenses on social determinants of health.
- "Dental Care" premium allocation and expenses until such time as this premium and expenses are added to risk model described here.
- "Non-Emergent Medical Transportation" premium allocation and expenses.
- CCO Quality Incentive Measure ("QIM") withhold return from the State of Oregon received in the year of settlement, whose distribution methodology is excluded as determined by the CCO Health Council.
- Operating payments to the CCO Health Council, taxes, adjustments and premium transfers.

(D) Contract terms that are consistent with the Joint Management Agreement (JMA) and JMA budget signed between Health Plan and the CCO Health Council which specifies the rules, duties, obligation, limitations on Health Plan margin, "Health Services" allocations, and other obligations and expenses for Health Plan as a CCO.

(E) Metrics which specify the return of part or all of the Risk Withhold and Surplus which may result from health care expenses measured against the HCB.

2.0 COMPENSATION.

2.1 Fee For Service Reimbursement

SERVICE/PROCEDURE	MAXIMUM ALLOWABLE	PERFORMANCE WITHHOLD
Outpatient Mental Health Services: 90785, 90832-90834, 90836-90840, 90846, 90847, 90849, 90853, 90882, 90887, H0004, H0032, T1023, T2010, T2011	132% of OHP Allowable[1, 2, 3]	10%
Outpatient Behavioral Health Assessments: 90791, 90792, 96130-96133, 96136, 96137, H0001, H0031, H2000	164% of OHP Allowable[1, 2, 3]	10%
Other Outpatient Substance Use Disorder Services: H0002, H0004 (HF or HG), H0005, H0006, H0020, H0022, H0033, T1006	132% of OHP Allowable[1, 2, 3]	10%
Evaluation and Management Services: 99202-99205, 99211-99215, 99354, 99355	164% of OHP Allowable[1, 2, 3]	10%
ABA Therapy Services	100% of OHP Allowable[1, 2, 3]	10%
THW Services: Consistent with PacificSource guidelines	100% of OHP Allowable[1, 2, 3]	10%
Laboratory, DME: Services listed in the OHP Medical-Dental Fee Schedule	100% of OHP Allowable[1, 2]	10%
Injectables, Vaccines, Immunizations: Services listed in the OHP Medical-Dental Fee Schedule	100% of Billed Charge	10%
Services and procedures not otherwise listed in this Attachment Services listed in the OHP Behavioral Health Fee Schedule Services listed in the OHP Medical-Dental Fee Schedule	 100% of OHP Allowable[1,2] 100% of OHP Allowable[1,2]	10%
Services and procedures without an established unit value listed above: PacificSource Health Plans may establish such unit values for purposes of its Maximum Allowable rate determination.	PacificSource Community Solutions Default Fee Allowance[4]	10%

Note: Payment will be based upon the lesser of the billed amount or PacificSource negotiated rates in effect at the time of service or supplies are rendered or provided as specified above.

1. PacificSource will reimburse based on the rates published as of the date of adjudication.
2. Updates to the schedules noted above shall be updated in accordance with OHP.
3. OHP Behavioral Health Fee Schedule is primary, OHP Medical-Dental Fee Schedule is secondary.
4. PacificSource utilizes industry standard publications and rate methods to supplement codes not established by the above noted methodologies.

2.2 Program-Based Reimbursement

Reimbursement for the services and programs defined below will be calculated as a per-member per-month (PMPM) payment based on full CCO (not county-specific) membership eligible for behavioral health benefits. The PMPM payment will be made prospectively based on the rates listed below with retroactive reconciliation as described below completed by Health Plan based on quarterly Provider reports using Health Plan's reporting template.

Services and Programs	Unit of Measure	$ per Unit
Youth Fidelity Wraparound Program (inclusive of all services, including those sub-contracted)	Per-Member Per-Month	$1,131.00[1]

1. On or before the 5th of the month, Provider shall send an invoice to Health Plan for Children's Wraparound Care Coordination. The invoice must include members served in the previous month and include the following data:

- Member name
- Member date of birth
- Medicaid ID number

Services and Programs	Unit of Measure	$ per Unit	Actual Payment Per Unit or PMPM
Professional Supervision for Licensure	Per supervision Session (60/45/30 minute increments), paid quarterly	60 = $435.55 45 = $295.89 30 = $200.65	
Local Public Health Authority Services	Per member per month		$0.32
Local Mental Health Authority Services (i.e. residential care coordination, civil commitment, system coordination)	Per member per month		$0.16
Assertive Community Treatment	Per enrolled member per month	$2,305.00	
Community Support Services (CSS) Total	Per member per month		
Total Program Support			**$10.27**

Allocation of payment for Community Support Services			
Crisis			$2.42
Mobile Crisis			$0.69
Supported Employment-Education			$0.84
Early Psychosis including EASA			$0.84
SPMI Day Treatment			$0.98
Intensive Children's Services			$0.37
Her Place			$0.44
His Place			$0.44
Other CSS			$2.77

Services and Programs	Description, Conditions, and Reporting
Youth Fidelity Wraparound Program	Condition: Fidelity to OHA model Reporting: Monthly enrollment and enrollee encounters. On or before the 5th of the month, Provider shall send an invoice to Health Plan. This invoice shall indicate members served in a previous month and include the following data: • Member name • Member date of birth • Member identification number Payment: Health Plan shall verify member eligibility and coverage, prorating the monthly rate should the member have not been eligible for services for the entire month. Provider will submit additional data elements as determined by Health Plan in order to verify the services rendered and member eligibility.
Professional Supervision for Licensure	Description: Registered Associate is defined as individual who has completed education requirements and registered with their respective licensing board as they complete clinical hours for licensure. To quality for payment, Registered Associates must be employed by Provider and have entered into a board-approved supervisory agreement with a Clinical Supervisor employed by a Provider. Reporting: Provider shall submit supervision log for supervision hours provided to Registered Associates on or before 15 days following quarter's end. Annually (on or before January 15th), provider will submit roster of Registered Associates that Provider staff had supervision agreements with in prior year. Provider will include the supervision agreement for each Registered Associate listed. Payment: Payment is calculated by estimating potential revenue lost due to Clinical Supervisor and Registered Associate not being able to bill for psychotherapy services during supervision time. Payment may be recouped if evidence of a supervision agreement between the Registered Associate and Clinical Supervisor is not provided.
Assertive Community Treatment (ACT)	Reporting: Monthly enrollment and enrollee encounters. Provider shall send an invoice to Health Plan n or before the 5th of the

Services and Programs	Description, Conditions, and Reporting
	month. This invoice shall indicate members served in a previous month and include the following data: • Member name • Member date of birth • Member identification number Payment: Health Plan shall verify member eligibility and coverage, prorating the monthly rate should the member have not been eligible for services for the entire month. Provider will submit additional data elements as determined by Health Plan in order to verify the services rendered and member eligibility.
Community Support Services (CSS) Total	Reporting: Actual expenditures, enrollment, performance, and outcomes. Payment: Allocation of Program Support payment across CSS may be recalculated during the third quarter of each calendar year based on Provider's prior fiscal year budget and actual financials.

The following codes will be encountered at 100% of OHP fee schedule but not paid because payment is included in the Services and Program payments detailed above:

Services and Programs	Codes
Youth Fidelity Wraparound	H2011, H2022
Fidelity Assertive Community Treatment	H0039
Day Treatment	H0036
Crisis	H2011, S9484, S9125
Early Psychosis including EASA	
Peer Support Services	H0038
Supported Employment/Education	H2023
Intensive Children's Services	
Additional Community Support Services	G0176, G0177, H0034, H0046, H2010, H2014, H2018, H2027, H2032, H2033, T1016, H2021

2.3 Performance Withhold Return Contingent On Quality

One hundred percent (100%) of any Provider's Performance Withhold return will be paid contingent on the performance of the performance measures defined in this Attachment, some of which are established and measured by the State of Oregon for the entire CCO and will be awarded based on such State of Oregon measurement and State of Oregon final payment for the CCO.

3.0 SETTLEMENT PERAMETERS.

3.1 Settlement Parameters

The following settlement parameters for this section pertain for OHP members assigned to Provider.

3.2 Time Period.

Annual Performance Withhold settlement will occur for the calendar year in the month of August after the close of the contract period ending December 31st. Performance Withhold return will be made to Provider in the month of August after final OHA determinations of QIM revenue determinations.

3.3 Performance Withhold Settlement Summary.

Health Plan shall be responsible for computing, documenting, and reporting to Provider an annual Performance Withhold settlement summary. This report shall be submitted to Provider in the month of August after year-end.

3.4 Budget Surplus or Deficit

For the contract period for the experience of Members assigned to any physical health primary care provider with a risk/incentive model in their agreement with Health Plan, the Health Care Budget will be compared to actual expenses incurred to determine whether a Surplus or Deficit exists.

3.4.1 Value Based Payment.

Provider will cooperate with Health Plan in complying with OHA requirements for value-based payments in the areas of: Maternity, Hospital, Pediatric, Behavioral Health and Oral Health care. As such, Performance Withhold return may be contingent on a specific array of metrics pertaining to these OHA-required areas as determined by Health Plan and Provider.

3.4.2 Unearned Performance Withhold

Any Unearned Performance Withhold shall be allocated in the following order:

1st Used to contribute to Health Plan's limited margin, consistent with the limitation in the Joint Management Agreement (JMA) between Health Plan and the CCO Health Council.

2nd Any remaining Unearned Performance Withhold Payment will be treated as shared savings under the terms of the JMA.

4.0 PERFORMANCE MEASURES AND REPORTING.

4.1 Performance Measures

Any Performance Withhold Distribution to Provider shall be based on the below, with the weight of each performance measure representing the percentage of return to be paid based on achieving the measure.

4.2 Performance Reports

Performance measure reports from Provider shall be submitted using Health Plan's ShareFile site by 11:59pm on the due date stated. Late submissions will incur a 25% penalty on weighted performance withhold value per partial or full week that reporting is submitted after the due date.

5.0 GENERAL PROVISIONS.

5.1 Requirements

Provider will cooperate with Health Plan on Health Plan's CAHPS Improvement Plans.

Provider allow Health Plan to share individual provider performance with CCO Health Councils.

Provider will collaborate with Health Plan to gain consensus through the CCO Health Council on maximizing and distributing Quality Pool funds from OHA.

Provider will collaborate with Health Plan to comply with the OHA Health Plan Quality Metrics Committee (HPQMC), with Health HPlan responsible for describing quality metrics from the HPQMC that will be used.

Provider will collaborate with Health Plan to comply with OHA's Practitioner Incentive Plan (PIP) reporting.

Provider will cooperate with Health Plan to collaborate on fulfilling any OHA requirements in the increased adoption of Health Information Exchange (HIE), Health Information Technology (HIT), and Electronic Health Record (EHR) technology.

5.2 Oregon Health Plan/OHA Capitation Administration Regulations

In the event of (a) new or changing requirements, rules, regulations or guidance related to applicable provider capitation payments made by Health Plan to Provider, and per Health Plan Exhibit L filing and Medical Loss Ratio filings submitted to OHA, and/or (b) Health Plan's and/or OHA's interpretation of applicability of such requirements, rules, regulations, or guidance and applicability of Health Plan's capitation payment methodology with Provider, Health Plan may enact the following:

- A charge commensurate with any OHA recoupment, demand for repayment, charge, tax or fee, to be charged against the CCO Health Care Budget, and/or
- A renegotiation with Provider to revert all payment methodologies entailing Provider capitation, to a fee-for-service payment methodology.

Provider shall cooperate with Health Plan to produce reports for Health Plan and/or OHA that satisfy to Health Plan and OHA discretion, the requirements, rules, regulations or guidance from OHA related to capitation payments.

5.3 Oregon Health Plan/OHA Possible Premium Revision / MLR-based repayment to OHA

In the event of a revision of premium levels for OHP members by the State of Oregon/OHA by a net amount deemed by Health Plan to be inconsistent with the reimbursement agreed to in this 2020 Agreement, Health Plan will notify Provider of such inconsistency in writing, and both parties will enter into a renegotiation of 2020 reimbursement rates to achieve consistency with any new Oregon Health Plan/OHA premium levels.

In the event OHA determines Health Plan must pay OHA any sum because the CCO Medical Loss Ratio (MLR), as determined by OHA, does not meet a minimum threshold for the entire population or any benefit-category specific sub populations, PacificSource reserves the right to (a) deduct a pro-rata portion of such repayment from the Health Care Budget in Section 6, or (b) make direct investments to increase the MLR and offset such expenses with the settlement, upon communication with Provider and the CCO Health Council.

5.4 MLR Reporting.

This reporting pertains specifically to the Exhibit L Financial Reporting Supplemental SE. Provider shall submit to Health Plan a report for each clinic for the cost time period of January 1 – June 30 by July 31, using a format accepted by the OHA. Provider shall submit to Health Plan a report for each clinic for the cost year January 1 – December 31 by February 28, using a format accepted by the OHA. Provider shall refer to the OHA CCO Contract Forms website at https://www.oregon.gov/oha/HSD/OHP/pages/cco-contract-forms.aspx for support. Any changes to reporting requirements set forth by the OHA will supersede the above requirements.

5.4 Community Health Improvement Plan, Transformation Plan and Health Council Activities.

Provider will collaborate with Health Plan, the CCO Health Council, and other stakeholders in completing a Community Health Assessment (CHA) and a Community Health Improvement Plan (CHIP), and in carrying out activities to implement the CHIP including any recommendation tied to community access studies. Provider will collaborate with PacificSource, the CCO Health Council, and other stakeholders to carry out the Transformation And Quality Strategies. For purposes of the CHA, CHIP, or Transformation And Quality Strategies, for reporting to the CCO Health Council or any of its subcommittees, or for reporting to OHA, PacificSource may share Provider utilization, membership numbers, and additional performance data. Provider will collaborate with PacificSource and the CCO Health Council to meet Transformation And Quality Strategies requirements and participate in Transformation And Quality Strategy projects.

5.6 Value-Based Payment.

Provider agrees to participate in Health Plan's Value-Based Payment (VBP) program, consistent with OHA requirements in which an increasing portion of provider payment conforms to the Learning and Action Network (LAN) category 2C or higher, which may entail the following elements.

- Payment based on any of the above methodologies
- Payment Withhold
- Surplus sharing
- Payment models to support care transformation and quality improvement in the following areas:

  Hospital Care
  Maternity Care
  Children's Care

Behavioral Health Care
Oral Health Care

In collaboration with Provider, PacificSource will share with Provider information pertaining to Health Information Technology (HIT) to support success in effective participation with the VBP program.

6.0 MISCELLANEOUS.

6.1 Defined Terms

Any terms not otherwise defined herein shall have the meaning set forth in the Participating Provider Agreement.

6.2 Precedence

Any conflict or inconsistency shall be resolved by giving precedence to this Attachment first then the Participating Provider Agreement.

ADDENDUM

Marion County, a political subdivision of the State of Oregon

01/01/2024

Youth Fidelity Wraparound

RECITALS

A. Wraparound is an intensive care coordination process for youth with emotional and behavioral disorders who are involved in multiple systems. These systems include, but are not limited to, mental health, addictions, child welfare, intellectual or developmental disabilities, juvenile justice, and education. Wraparound is a team-based, strengths-based process that organizes a youth-and-family-driven system of services and supports. Services and supports are individualized for a youth and family to achieve a positive set of outcomes.

B. Provider is committed to participating in supporting the continuum of care that integrates health services by means of implementing a System of Care approach that includes models such as Wraparound for children with behavioral health disorders.

C. Provider serves as a Wraparound Provider or supports multiple Wraparound Providers, and Provider specializes in providing Wraparound supports to eligible Members in accordance with OAR 309-019-0326. Provider delivers Wraparound supports pursuant to Fidelity Wraparound requirements, as required by OAR 309-019-0326 and Exhibit M of the CCO Contract.

1. WRAPAROUND WORK.

Health Plan retains Provider to create, support, and manage the services for its Members in the Service Area as described and in accordance with this Section 1 (the "Wraparound Work"). Provider agrees to render all Wraparound Work in accordance with the terms and conditions of the Agreement and this Attachment, applicable state and federal law, applicable government regulations and guidance, and in conformity with appropriate and accepted standards of care for those services. Nothing herein is intended to create, and shall not create, any exclusive arrangement between Health Plan and Provider. This Agreement shall not restrict either Party from acquiring similar, equal or like goods or services from other entities or sources. The Parties acknowledge that there may be changes in OHA guidance or interpretation in the future that impact this Agreement. The Parties agree to work together to adjust and incorporate such OHA guidance and interpretations into this Agreement and/or into the work performed hereunder, as well as any new requirements from an amendment to the CCO Contract or as otherwise required by OHA. Provider shall perform Wraparound Work, as described in greater detail below:

1.1 Wraparound Services. Provider shall administer Wraparound care coordination services to Fidelity, consistent with the obligations specifically related to Wraparound services set forth in OAR 309-019-0326 and Exhibit M of the CCO Contract. In particular, Provider shall:

- Ensure certified providers administer the Child and Adolescent Needs and Strengths Assessment ("CANS") Oregon to members, consistent with the requirements set forth in Exhibit M of the CCO Contract, including input of CANS data into state data system. All staff administering the CANS must be certified by the Praed Foundation;
- Ensure its providers and staff are trained in integration and foundations of Trauma Informed Care, recovery principles, motivational interviewing, assessing for Adverse Childhood Experiences, and rendering services in a Culturally and Linguistically Appropriate manner;
- Adhere to applicable elements of the System of Care Wraparound Initiative Guidance Document published by the OHA; and
- Complete required documents for each enrolled youth and their family pursuant to the Fidelity model.
- Input member information into state's Fidelity and Monitoring System, WrapStat, including: Medicaid ID numbers, Wraparound enrollments, discharges, and member demographic information.
- Distribute WFI-EZs according to the evaluation cycles identified in WrapStat, ensuring all youth and members of their Wraparound team who are a part of the evaluation cycle are provided the opportunity to complete a WFI-EZ. WFI-EZs can be collected electronically through WrapStat or in hard copy format, with all paper copies required to be submitted to Health Plan for entry into WrapStat.
- Complete TOMs during evaluation cycles identified in WrapStat.

1.2 **Clients Served.** Provider shall be reimbursed for the number of Wraparound clients served each month. Provider will be responsible for invoicing PacificSource on a monthly basis to indicate youth enrolled in Wraparound program.

1.3 **PacificSource's Wraparound Policies.** Provider agrees to comply with Health Plan's Wraparound policies and procedures, including those policies and procedures specifically related to Wraparound services described in Exhibit M of the CCO Contract. Provider also agrees to provide feedback not less than annually in order to support Health Plan in improving its policies and procedures to meet the needs of the local community.

1.4 **Wraparound Staff.** Provider will ensure the implementation of Fidelity Wraparound by hiring and training the following staff required in Exhibit M to deliver Wraparound Work:

- Wraparound Care Coordinator;
- Wraparound Supervisor;
- Wraparound Coach;
- Youth Peer Delivered Service Provider;
- Family Peer Delivered Service Provider; and
- Peer Delivered Service Provider Supervisor.

1.5 Workforce. On not less than a quarterly basis, Provider agrees to share with Health

Plan a summary of its workforce, including whether any of its employed or contracted workforce are certified or grandfathered as traditional health workers, as well as their corresponding scope of practice using a THW reporting template supplied by Health Plan. This information is required by the OHA, and allows the Health Plan to develop targeted strategies to meet member health needs. After Provider produces this analysis, the Parties agree to meet and review the analysis to discuss barriers and opportunities.

1.6 Assistance in Meeting OHA Obligations. Provider agrees to cooperate with and assist PacificSource in fulfilling PacificSource's obligations to the OHA with regard to services performed under this Agreement. Notwithstanding the foregoing, nothing in this Attachment will require Provider to provide oral health or physical health interventions unless otherwise agreed to by the parties.

1.7 Behavioral Health Report. Provider agrees to collaborate with Health Plan to complete reporting to the OHA, including the Behavioral Health Report that Health Plan must submit to the OHA on an annual basis.

1.8 Wraparound Collaboration. Provider agrees to work collaboratively with Health Plan staff, as reasonably requested. Provider also agrees to participate in technical assistance offered by Health Plan, including training in trauma-informed care principles.

1.9 Participation in System of Care Governance. Provider agrees to participate in System of Care work groups, including the Practice Level Workgroup, to support a comprehensive, person-centered, individualized, and integrated community-based array of child and youth behavioral health services using System of Care principles.

1.10 Participation in Community Governance. Provider agrees to participate in the local Community Health Assessment and Community Health Improvement Plan, as may be requested by Health Plan, from time to time. In addition, Provider agrees to participate in the Community Advisory Council to share valuable perspectives with the community.

1.11 Caseloads. Provider shall track the ratio of care coordinators, family support specialists, and youth support specialists to families served. Provider shall maintain adequate staffing in order to ensure that at no time the ratio of providers to families served exceeds 1:15. If at any time the ratio exceeds 1:15, Provider shall immediately notify Health Plan so that Health Plan may take appropriate next steps pursuant to Health Plan's policies and procedures.

1.12 Data Collection and Reporting. In order to support Provider and Health Plan's joint efforts to serve Members and in service of the OHA's requirements to collect data about the delivery of Wraparound services, Provider agrees to provide reporting to Health Plan that includes the following:

- Wraparound Annual Utilization Report (annually)
- Number of youth served (quarterly)

- Ratio of employed or contracted staff to total number of youth served (quarterly)
- Number of requests for Wraparound services and number enrolled in Wraparound, including explanations for those not enrolled (quarterly)
- Number of youth discharged from Wraparound (quarterly)
- Race/Ethnicity and Language of eligible members enrolled in and discharged from Wraparound (quarterly)

1.13 Reporting Penalties. Provider agrees to supply the reporting deliverables listed in Section 1.12. Provider agrees to indemnify and hold Health Plan harmless against any and all fines, fees, and/or assessments assessed by the Oregon Health Authority as a result of Provider's failure to timely meet the reporting deliverables identified in this Agreement.

1.14 Encounter Data. Provider agrees to submit claims for all Wraparound services provided by Wraparound staff, as identified in Section 1.4. All Wraparound services (excluding CANS assessments billed using H2000) shall be submitted and include the member's diagnosis or diagnoses, Procedure Code H2021, Community-based Wraparound Services, per 15 minutes, and the number of units per service (e.g., a 45 minute encounter would require claim submission of H2021 for 3 units). These claims are for encounter reporting purposes only and will not be reimbursed, per payment agreement in Attachment A.

1.15 Workforce Training. Provider shall ensure that all staff receive training as required in the Contract such as, but not limited to, Cultural Responsiveness, Implicit Bias, CLAS Standards, Trauma Informed Care, and uses of data to advance health equity to name a few. Provider and provider staff may access trainings offered by the PacificSource Training Program. For all other training, Provider shall have mechanisms in place that enable reporting to Health Plan, at Health Plan's reasonable request, details of training activities, annual training plans, training subjects, content outlines, objectives, target audiences, delivery system, evaluations, training hours, training attendance, and trainer qualifications. At a minimum, Provider shall provide Health Plan with an Annual Training and Education Report so that Health Plan may compile such information into Health Plan's report to the OHA.

2. PAYMENT.

Provider shall be paid for providing the Wraparound Work pursuant to Attachment A of the Agreement.

3. TERM AND TERMINATION.

This Addendum shall be in full force and effect for the Term of the Agreement, unless earlier terminated as provided herein. Either Party may terminate this Addendum, without impacting the Agreement, with the other Party's written consent, which shall not be unreasonably withheld.

4. DATA USE.

The Parties recognize and agree that it may be necessary to share certain data with each other that was not anticipated to give this Addendum its full force and effect. The Parties agree that they will meet and determine the exact data to provide, in accordance with the

terms of this Addendum, as it becomes necessary. The additional specifications for that data may be added as an amendment, at any time, to this Addendum as mutually agreed to by the Parties. The Parties acknowledge that the CCO Contract requires significant reporting to OHA, including documentation establishing compliance with OAR 309-019-0326, and agree to work together to ensure the proper completion and filing of such reports so that Health Plan may fulfill its obligations under the CCO Contract. Provider acknowledges that OHA will post many of the reports on its website. Where redaction of certain information is allowed, the Parties will coordinate on the identification of those redactions, although Health Plan will have the right to make the final redactions based on its sole discretion.

PacificSource Community Solutions

AMENDMENT TO

PacificSource / Marion County, a political subdivision of the State of Oregon

PARTICIPATING PROVIDER SERVICE AGREEMENT

Effective January 01, 2023 the PacificSource Participating Provider Service Agreement with Marion County, a political subdivision of the State of Oregon is amended as follows:

I. **Attachment A-2** dated effective 07/01/2022 shall be replaced with **Amended Attachment A-2** dated effective 01/01/2023.

II. **Cover All Kids Attachment A** dated effective 01/01/2020 shall be replaced with **Amended Healthier Oregon Program Attachment A** dated effective 01/01/2023.

III. **Youth Fidelity Wraparound Addendum** shall be added effective 01/01/2023.

Except for the changes described herein, the Participating Provider Service Agreement remains unchanged.

PACIFICSOURCE COMMUNITY SOLUTIONS

By: Peter McGarry
(Signature)

Peter McGarry

Title: Vice President – Provider Network

Date: 4/28/2023

MARION COUNTY, A POLITICAL SUBDIVISION OF THE STATE OF OREGON

DocuSigned by:
By: Ryan Matthews
7D28A787656F458...
(Signature)

Ryan Matthews
(Print or type name)

Title: HHS Administrator

Date: 4/19/2023

SIGNATURE PAGE for HE-3063-19, AMD #10
between
MARION COUNTY and PACIFICSOURCE COMMUNITY SOLUTIONS

MARION COUNTY SIGNATURES
BOARD OF COMMISSIONERS:

Chair — Date: 4/26/2023

Commissioner — Date: 4.26.2023

Not Present At Meeting

Commissioner — Date

Authorized Signature: DocuSigned by: Jan Fritz DC16351248DE4EC... — Date: 4/21/2023
Chief Administrative Officer

Reviewed by Signature: DocuSigned by: Jane E. Vetto D0CFC5B04B9F483... — Date: 4/20/2023
Marion County Legal Counsel

Reviewed by Signature: DocuSigned by: Camber Schlag C5B2F3DF257F444... — Date: 4/19/2023
Marion County Contracts & Procurement

Attachment A-2

Marion County, a political subdivision of the State of Oregon

January 1, 2023

Reimbursement Schedule – Risk/Incentive Model

Community Mental Health Program

1.0 RISK/INCENTIVE MODEL.

The Risk/Incentive model agreed upon by Health Plan and Provider shall contain the following:

(A) A risk/incentive model involving multiple community Health Care Budgets for populations of Members assigned to specific physical health primary care providers, derived from revenue allocated for the physical health and behavioral health care needs of Members, and a settlement for providers with budget-based aligned incentives as indicated in this Attachment A.

(B) Fee-for-service payment for professional services provided by Provider with a Claims Risk Withhold, in addition to program-based PMPM reimbursement where appropriate.

(C) For distinct OHP Member populations assigned to physical health primary care providers with risk/incentive models in their agreements with Health Plan. A risk/incentive model which features Revenue and Expenses for physical health and behavioral health professional and residential services under OHP and paid by the State of Oregon to Health Plan as a global capitation payment, and less revenue reductions pertaining to (i) Hepatitis C reconciliations (as reconciled with the State of Oregon if necessary), (ii) HRA adjustments, taxes, premium transfers and other OHA mandated premium reductions, and (iii) excluding Revenue and Expenses in the following categories:

- State of Oregon mandated spending/expenses on social determinants of health.
- "Dental Care" premium allocation and expenses until such time as this premium and expenses are added to risk model described here.
- "Non-Emergent Medical Transportation" premium allocation and expenses.
- CCO Quality Incentive Measure ("QIM") withhold return from the State of Oregon received in the year of settlement, whose distribution methodology is excluded as determined by the CCO Health Council.
- Operating payments to the CCO Health Council, taxes, adjustments and premium transfers.

(D) Contract terms that are consistent with the Joint Management Agreement (JMA) and JMA budget signed between Health Plan and the CCO Health Council which specifies the rules, duties, obligation, limitations on Health Plan margin, "Health Services" allocations, and other obligations and expenses for Health Plan as a CCO.

(E) Metrics which specify the return of part or all of the Risk Withhold and Surplus which may result from health care expenses measured against the HCB.

2.0 COMPENSATION.

2.1 Fee For Service Reimbursement

SERVICE/PROCEDURE	MAXIMUM ALLOWABLE	PERFORMANCE WITHHOLD
Outpatient Mental Health Services: 90785, 90832-90834, 90836-90840, 90846, 90847, 90849, 90853, 90882, 90887, H0032, T1023, T2010, T2011	132% of OHP Allowable[1, 2, 3]	10%
Outpatient Behavioral Health Assessments: 90791, 90792, 96130-96133, 96136, 96137, H0001, H0031, H2000	160% of OHP Allowable[1, 2, 3]	10%
Other Outpatient Substance Use Disorder Services: H0002, H0004-H0006, H0020, H0022, H0033, T1006	132% of OHP Allowable[1, 2, 3]	10%
Evaluation and Management Services: 99202-99205, 99211-99215, 99354, 99355	160% of OHP Allowable[1, 2, 3]	10%
ABA Therapy Services	100% of OHP Allowable[1, 2, 3]	10%
THW Services: Consistent with PacificSource guidelines	100% of OHP Allowable[1, 2, 3]	10%
Laboratory, DME: Services listed in the OHP Medical-Dental Fee Schedule	100% of OHP Allowable[1, 2]	10%
Injectables, Vaccines, Immunizations: Services listed in the OHP Medical-Dental Fee Schedule	100% of Billed Charge	10%
Services and procedures not otherwise listed in this Attachment Services listed in the OHP Behavioral Health Fee Schedule Services listed in the OHP Medical-Dental Fee Schedule	 100% of OHP Allowable[3] 100% of OHP Allowable[3]	10%
Services and procedures without an established unit value listed above: PacificSource Health Plans may establish such unit values for purposes of its Maximum Allowable rate determination.	PacificSource Community Solutions Default Fee Allowance[4]	10%

Note: Payment will be based upon the lesser of the billed amount or PacificSource negotiated rates in effect at the time of service or supplies are rendered or provided as specified above.
1. PacificSource will reimburse based on the rates published as of the date of adjudication.
2. Updates to the schedules noted above shall be updated in accordance with OHP.
3. OHP Behavioral Health Fee Schedule is primary, OHP Medical-Dental Fee Schedule is secondary.
4. PacificSource utilizes industry standard publications and rate methods to supplement codes not established by the above noted methodologies.

2.2 Program-Based Reimbursement

Reimbursement for the services and programs defined below will be calculated as a per-member per-month (PMPM) payment based on full CCO (not county-specific) membership eligible for behavioral health benefits. The PMPM payment will be made prospectively based on the rates listed below with retroactive reconciliation as described below completed by Health Plan based on quarterly Provider reports using Health Plan's reporting template.

Services and Programs	Unit of Measure	$ per Unit
Youth Fidelity Wraparound Program (inclusive of all services, including those sub-contracted)	Per-Member Per-Month	$1,110[1]

1. On or before the 5th of the month, Provider shall send an invoice to Health Plan for Children's Wraparound Care Coordination. The invoice must include members served in the previous month and include the following data:

- Member name
- Member date of birth
- Medicaid ID number

Services and Programs	Unit of Measure	$ per Unit	Actual Payment Per Unit or PMPM
Professional Supervision for Licensure	Per supervision Session (60/45/30 minute increments), paid quarterly	60 = $435.55 45 = $295.89 30 = $200.65	
Local Public Health Authority Services	Per member per month		$0.31
Local Mental Health Authority Services (i.e. residential care coordination, civil commitment, system coordination)	Per member per month		$0.16
Assertive Community Treatment	Per enrolled member per month	$2,262.00	
Community Support Services (CSS) Total	Per member per month		
Total Program Support			**$9.73**

Allocation of payment for Community Support Services				
Crisis (including Mobile)				$2.72
Supported Employment-Education				$0.82
Early Psychosis including EASA				$0.82
SPMI Day Treatment				$0.96
Intensive Children's Services				$0.36
Her Place				$0.43
His Place				$0.43
Other CSS				$2.72

Services and Programs	Description, Conditions, and Reporting
Youth Fidelity Wraparound Program	Condition: Fidelity to OHA model Reporting: Monthly enrollment and enrollee encounters. On or before the 5th of the month, Provider shall send an invoice to Health Plan. This invoice shall indicate members served in a previous month and include the following data: • Member name • Member date of birth • Member identification number Payment: Health Plan shall verify member eligibility and coverage, prorating the monthly rate should the member have not been eligible for services for the entire month. Provider will submit additional data elements as determined by Health Plan in order to verify the services rendered and member eligibility.
Professional Supervision for Licensure	Description: Registered Associate is defined as individual who has completed education requirements and registered with their respective licensing board as they complete clinical hours for licensure. To quality for payment, Registered Associates must be employed by Provider and have entered into a board-approved supervisory agreement with a Clinical Supervisor employed by a Provider. Reporting: Provider shall submit supervision log for supervision hours provided to Registered Associates on or before 15 days following quarter's end. Annually (on or before January 15th), provider will submit roster of Registered Associates that Provider staff had supervision agreements with in prior year. Provider will include the supervision agreement for each Registered Associate listed. Payment: Payment is calculated by estimating potential revenue lost due to Clinical Supervisor and Registered Associate not being able to bill for psychotherapy services during supervision time. Payment may be recouped if evidence of a supervision agreement between the Registered Associate and Clinical Supervisor is not provided.
Assertive Community Treatment (ACT)	Reporting: Monthly enrollment and enrollee encounters. Provider shall send an invoice to Health Plan n or before the 5th of the month. This invoice shall indicate members served in a previous month and include the following data:

Services and Programs	Description, Conditions, and Reporting
	• Member name • Member date of birth • Member identification number Payment: Health Plan shall verify member eligibility and coverage, prorating the monthly rate should the member have not been eligible for services for the entire month. Provider will submit additional data elements as determined by Health Plan in order to verify the services rendered and member eligibility.
Community Support Services (CSS) Total	Reporting: Actual expenditures, enrollment, performance, and outcomes. Payment: Allocation of Program Support payment across CSS may be recalculated during the third quarter of each calendar year based on Provider's prior fiscal year budget and actual financials.

The following codes will be encountered at 100% of OHP fee schedule but not paid because payment is included in the Services and Program payments detailed above:

Services and Programs	Codes
Youth Fidelity Wraparound	H2011, H2022
Fidelity Assertive Community Treatment	H0039
Day Treatment	H0036
Crisis	H2011, S9484, S9125
Early Psychosis including EASA	
Peer Support Services	H0038
Supported Employment/Education	H2023
Intensive Children's Services	
Additional Community Support Services	G0176, G0177, H0034, H0046, H2010, H2014, H2018, H2027, H2032, H2033, T1016, H2021

2.3 Performance Withhold Return Contingent On Quality

One hundred percent (100%) of any Provider's Performance Withhold return will be paid contingent on the performance of the performance measures defined in this Attachment, some of which are established and measured by the State of Oregon for the entire CCO and will be awarded based on such State of Oregon measurement and State of Oregon final payment for the CCO.

3.0 SETTLEMENT PERAMETERS.

3.1 Settlement Parameters

The following settlement parameters for this section pertain for OHP members assigned to Provider.

3.2 Time Period.

Annual Performance Withhold settlement will occur for the calendar year in the month of August after the close of the contract period ending December 31st. Performance Withhold return will be made to Provider in the month of August after final OHA determinations of QIM revenue determinations.

3.3 Performance Withhold Settlement Summary.

Health Plan shall be responsible for computing, documenting, and reporting to Provider an annual Performance Withhold settlement summary. This report shall be submitted to Provider in the month of August after year-end.

3.4 Budget Surplus or Deficit

For the contract period for the experience of Members assigned to any physical health primary care provider with a risk/incentive model in their agreement with Health Plan, the Health Care Budget will be compared to actual expenses incurred to determine whether a Surplus or Deficit exists.

3.4.1 Value Based Payment.

Provider will cooperate with Health Plan in complying with OHA requirements for value-based payments in the areas of: Maternity, Hospital, Pediatric, Behavioral Health and Oral Health care. As such, Performance Withhold return may be contingent on a specific array of metrics pertaining to these OHA-required areas as determined by Health Plan and Provider.

3.4.2 Unearned Performance Withhold

Any Unearned Performance Withhold shall be allocated in the following order:

1st Used to contribute to Health Plan's limited margin, consistent with the limitation in the Joint Management Agreement (JMA) between Health Plan and the CCO Health Council.

2nd Any remaining Unearned Performance Withhold Payment will be treated as shared savings under the terms of the JMA.

4.0 PERFORMANCE MEASURES AND REPORTING.

4.1 Performance Measures

Any Performance Withhold Distribution to Provider shall be based on the below, with the weight of each performance measure representing the percentage of return to be paid based on achieving the measure.

4.2 Performance Reports

Performance measure reports from Provider shall be submitted using Health Plan's ShareFile site by 11:59pm on the due date stated. Late submissions will incur a 25% penalty on weighted performance withhold value per partial or full week that reporting is submitted after the due date.

5.0 GENERAL PROVISIONS.

5.1 Requirements

Provider will cooperate with Health Plan on Health Plan's CAHPS Improvement Plans.

Provider allow Health Plan to share individual provider performance with CCO Health Councils.

Provider will collaborate with Health Plan to gain consensus through the CCO Health Council on maximizing and distributing Quality Pool funds from OHA.

Provider will collaborate with Health Plan to comply with the OHA Health Plan Quality Metrics Committee (HPQMC), with Health HPlan responsible for describing quality metrics from the HPQMC that will be used.

Provider will collaborate with Health Plan to comply with OHA's Practitioner Incentive Plan (PIP) reporting.

Provider will cooperate with Health Plan to collaborate on fulfilling any OHA requirements in the increased adoption of Health Information Exchange (HIE), Health Information Technology (HIT), and Electronic Health Record (EHR) technology.

5.2 Oregon Health Plan/OHA Capitation Administration Regulations

In the event of (a) new or changing requirements, rules, regulations or guidance related to applicable provider capitation payments made by Health Plan to Provider, and per Health Plan Exhibit L filing and Medical Loss Ratio filings submitted to OHA, and/or (b) Health Plan's and/or OHA's interpretation of applicability of such requirements, rules, regulations, or guidance and applicability of Health Plan's capitation payment methodology with Provider, Health Plan may enact the following:

- A charge commensurate with any OHA recoupment, demand for repayment, charge, tax or fee, to be charged against the CCO Health Care Budget, and/or
- A renegotiation with Provider to revert all payment methodologies entailing Provider capitation, to a fee-for-service payment methodology.

Provider shall cooperate with Health Plan to produce reports for Health Plan and/or OHA that satisfy to Health Plan and OHA discretion, the requirements, rules, regulations or guidance from OHA related to capitation payments.

5.3 Oregon Health Plan/OHA Possible Premium Revision / MLR-based repayment to OHA

In the event of a revision of premium levels for OHP members by the State of Oregon/OHA by a net amount deemed by Health Plan to be inconsistent with the reimbursement agreed to in this 2020 Agreement, Health Plan will notify Provider of such inconsistency in writing, and both parties will enter into a renegotiation of 2020 reimbursement rates to achieve consistency with any new Oregon Health Plan/OHA premium levels.

In the event OHA determines Health Plan must pay OHA any sum because the CCO Medical Loss Ratio (MLR), as determined by OHA, does not meet a minimum threshold for the entire population or any benefit-category specific sub populations, PacificSource reserves the right to (a) deduct a pro-rata portion of such repayment from the Health Care Budget in Section 6, or (b) make direct investments to increase the MLR and offset such expenses with the settlement, upon communication with Provider and the CCO Health Council.

5.4 MLR Reporting.
This reporting pertains specifically to the Exhibit L Financial Reporting Supplemental SE. Provider shall submit to Health Plan a report for each clinic for the cost time period of January 1 – June 30 by July 31, using a format accepted by the OHA. Provider shall submit to Health Plan a report for each clinic for the cost year January 1 – December 31 by February 28, using a format accepted by the OHA. Provider shall refer to the OHA CCO Contract Forms website at https://www.oregon.gov/oha/HSD/OHP/pages/cco-contract-forms.aspx for support. Any changes to reporting requirements set forth by the OHA will supersede the above requirements.

5.4 Community Health Improvement Plan, Transformation Plan and Health Council Activities.
Provider will collaborate with Health Plan, the CCO Health Council, and other stakeholders in completing a Community Health Assessment (CHA) and a Community Health Improvement Plan (CHIP), and in carrying out activities to implement the CHIP including any recommendation tied to community access studies. Provider will collaborate with PacificSource, the CCO Health Council, and other stakeholders to carry out the Transformation And Quality Strategies. For purposes of the CHA, CHIP, or Transformation And Quality Strategies, for reporting to the CCO Health Council or any of its subcommittees, or for reporting to OHA, PacificSource may share Provider utilization, membership numbers, and additional performance data. Provider will collaborate with PacificSource and the CCO Health Council to meet Transformation And Quality Strategies requirements and participate in Transformation And Quality Strategy projects.

5.6 Value-Based Payment.
Provider agrees to participate in Health Plan's Value-Based Payment (VBP) program, consistent with OHA requirements in which an increasing portion of provider payment conforms to the Learning and Action Network (LAN) category 2C or higher, which may entail the following elements.

- Payment based on any of the above methodologies
- Payment Withhold
- Surplus sharing
- Payment models to support care transformation and quality improvement in the following areas:

  Hospital Care
  Maternity Care
  Children's Care
  Behavioral Health Care

Oral Health Care

In collaboration with Provider, PacificSource will share with Provider information pertaining to Health Information Technology (HIT) to support success in effective participation with the VBP program.

6.0 MISCELLANIOUS.

6.1 Defined Terms

Any terms not otherwise defined herein shall have the meaning set forth in the Participating Provider Agreement.

6.2 Precedence

Any conflict or inconsistency shall be resolved by giving precedence to this Attachment first then the Participating Provider Agreement.

ATTACHMENT A

Marion County, a political subdivision of the State of Oregon
Effective 01/01/2023
Reimbursement Schedule

These rates shall apply to applicable Healthier Oregon Program Networks and Products

SERVICE/PROCEDURE	MAXIMUM ALLOWABLE
All Medical Services: Services as defined in the OHP Medical-Dental Fee Schedule	100% of OHP Allowable[1, 2]
All Behavioral Health Services: Services as defined in the OHP Behavioral Health Fee Schedule	109% of OHP Allowable[1, 2]
Anesthesia: Service or supply with ASA Value	100% of OHP Allowable[2, 3]
Services and procedures without an established unit value listed above: PacificSource Health Plans may establish such unit values for purposes of its Maximum Allowable rate determination.	PacificSource Community Solutions Default Fee Allowance[4]

Note: Payment will be based upon the lesser of the billed amount or PacificSource negotiated rates in effect at the time the service or supplies are rendered or provided as specified above.

1. PacificSource will reimburse based on the rates published as of the date of adjudication.
2. Updates to the schedules noted above shall be updated in accordance with OHP.
3. ASA Basic Unit Value and annual updates as defined by the American Society of Anesthesiologists Relative Value Guide. Time units shall be based on fifteen (15) minute increments.
4. PacificSource utilizes industry standard publications and rate methods to supplement codes not established by the above noted methodologies.

ADDENDUM

Marion County, a political subdivision of the State of Oregon

1/1/2023

Youth Fidelity Wraparound

RECITALS

A. Wraparound is an intensive care coordination process for youth with emotional and behavioral disorders who are involved in multiple systems. These systems include, but are not limited to, mental health, addictions, child welfare, intellectual or developmental disabilities, juvenile justice, and education. Wraparound is a team-based, strengths-based process that organizes a youth-and-family-driven system of services and supports. Services and supports are individualized for a youth and family to achieve a positive set of outcomes.

B. Provider is committed to participating in supporting the continuum of care that integrates health services by means of implementing a System of Care approach that includes models such as Wraparound for children with behavioral health disorders.

C. Provider serves as a Wraparound Provider or supports multiple Wraparound Providers, and Provider specializes in providing Wraparound supports to eligible Members in accordance with OAR 309-019-0326. Provider delivers Wraparound supports pursuant to Fidelity Wraparound requirements, as required by OAR 309-019-0326 and Exhibit M of the CCO Contract.

1. WRAPAROUND WORK.

Health Plan retains Provider to create, support, and manage the services for its Members in the Service Area as described and in accordance with this Section 1 (the "Wraparound Work"). Provider agrees to render all Wraparound Work in accordance with the terms and conditions of the Agreement and this Attachment, applicable state and federal law, applicable government regulations and guidance, and in conformity with appropriate and accepted standards of care for those services. Nothing herein is intended to create, and shall not create, any exclusive arrangement between Health Plan and Provider. This Agreement shall not restrict either Party from acquiring similar, equal or like goods or services from other entities or sources. The Parties acknowledge that there may be changes in OHA guidance or interpretation in the future that impact this Agreement. The Parties agree to work together to adjust and incorporate such OHA guidance and interpretations into this Agreement and/or into the work performed hereunder, as well as any new requirements from an amendment to the CCO Contract or as otherwise required by OHA. Provider shall perform Wraparound Work, as described in greater detail below:

1.1 Wraparound Services. Provider shall administer Wraparound care coordination services to Fidelity, consistent with the obligations specifically related to Wraparound services set forth in OAR 309-019-0326 and Exhibit M of the CCO Contract. In particular, Provider shall:

- Ensure certified providers administer the Child and Adolescent Needs and Strengths Assessment ("CANS") Oregon to members, consistent with the requirements set forth in Exhibit M of the CCO Contract, including input of CANS data into state data system. All staff administering the CANS must be certified by the Praed Foundation;
- Ensure its providers and staff are trained in integration and foundations of Trauma Informed Care, recovery principles, motivational interviewing, assessing for Adverse Childhood Experiences, and rendering services in a Culturally and Linguistically Appropriate manner;
- Adhere to applicable elements of the System of Care Wraparound Initiative Guidance Document published by the OHA; and
- Complete required documents for each enrolled youth and their family pursuant to the Fidelity model.
- Input member information into state's Fidelity and Monitoring System, WrapStat, including: Medicaid ID numbers, Wraparound enrollments, discharges, and member demographic information.
- Distribute WFI-EZs according to the evaluation cycles identified in WrapStat, ensuring all youth and members of their Wraparound team who are a part of the evaluation cycle are provided the opportunity to complete a WFI-EZ. WFI-EZs can be collected electronically through WrapStat or in hard copy format, with all paper copies required to be submitted to Health Plan for entry into WrapStat.
- Complete TOMs during evaluation cycles identified in WrapStat.

1.2 Clients Served. Provider shall be reimbursed for the number of Wraparound clients served each month. Provider will be responsible for invoicing PacificSource on a monthly basis to indicate youth enrolled in Wraparound program.

1.3 PacificSource's Wraparound Policies. Provider agrees to comply with Health Plan's Wraparound policies and procedures, including those policies and procedures specifically related to Wraparound services described in Exhibit M of the CCO Contract. Provider also agrees to provide feedback not less than annually in order to support Health Plan in improving its policies and procedures to meet the needs of the local community.

1.4 Wraparound Staff. Provider will ensure the implementation of Fidelity Wraparound by hiring and training the following staff required in Exhibit M to deliver Wraparound Work:

- Wraparound Care Coordinator;
- Wraparound Supervisor;
- Wraparound Coach;
- Youth Peer Delivered Service Provider;
- Family Peer Delivered Service Provider; and
- Peer Delivered Service Provider Supervisor.

1.5 Workforce. On not less than a quarterly basis, Provider agrees to share with Health Plan a summary of its workforce, including whether any of its employed or contracted workforce are certified or grandfathered as traditional health workers, as well as their corresponding scope of practice using a THW reporting template supplied by Health Plan. This information is required by the OHA, and allows the Health Plan to develop targeted strategies to meet member health needs. After Provider produces this analysis, the Parties agree to meet and review the analysis to discuss barriers and opportunities.

1.6 Assistance in Meeting OHA Obligations. Provider agrees to cooperate with and assist PacificSource in fulfilling PacificSource's obligations to the OHA with regard to services performed under this Agreement. Notwithstanding the foregoing, nothing in this Attachment will require Provider to provide oral health or physical health interventions unless otherwise agreed to by the parties.

1.7 Behavioral Health Report. Provider agrees to collaborate with Health Plan to complete reporting to the OHA, including the Behavioral Health Report that Health Plan must submit to the OHA on an annual basis.

1.8 Wraparound Collaboration. Provider agrees to work collaboratively with Health Plan staff, as reasonably requested. Provider also agrees to participate in technical assistance offered by Health Plan, including training in trauma-informed care principles.

1.9 Participation in System of Care Governance. Provider agrees to participate in System of Care work groups, including the Practice Level Workgroup, to support a comprehensive, person-centered, individualized, and integrated community-based array of child and youth behavioral health services using System of Care principles.

1.10 Participation in Community Governance. Provider agrees to participate in the local Community Health Assessment and Community Health Improvement Plan, as may be requested by Health Plan from time to time. In addition, Provider agrees to participate in the Community Advisory Council to share valuable perspectives with the community.

1.11 Caseloads. Provider shall track the ratio of care coordinators, family support specialists, and youth support specialists to families served. Provider shall maintain adequate staffing in order to ensure that at no time the ratio of providers to families served exceeds 1:15. If at any time the ratio exceeds 1:15, Provider shall immediately notify Health Plan so that Health Plan may take appropriate next steps pursuant to Health Plan's policies and procedures.

1.12 Data Collection and Reporting. In order to support Provider and Health Plan's joint efforts to serve Members and in service of the OHA's requirements to collect data about the delivery of Wraparound services, Provider agrees to provide reporting to Health Plan that includes the following:

- Wraparound Staff Roster (annually)
- Number of youth served (quarterly)
- Ratio of employed or contracted staff to total number of youth served (quarterly)

- Number of requests for Wraparound services and number enrolled in Wraparound, including explanations for those not enrolled (quarterly)
- Number of youth discharged from Wraparound (quarterly)
- Race/Ethnicity and Language of eligible members enrolled in and discharged from Wraparound (quarterly)

1.13 Reporting Penalties. Provider agrees to supply the reporting deliverables listed in Section 1.12. Provider agrees to indemnify and hold Health Plan harmless against any and all fines, fees, and/or assessments assessed by the Oregon Health Authority as a result of Provider's failure to timely meet the reporting deliverables identified in this Agreement.

1.14 Encounter Data. Provider agrees to submit claims for all Wraparound services provided by Wraparound staff, as identified in Section 1.4. All Wraparound services (excluding CANS assessments billed using H2000) shall be submitted and include the member's diagnosis or diagnoses, Procedure Code H2021, Community-based Wraparound Services, per 15 minutes, and the number of units per service (e.g., a 45 minute encounter would require claim submission of H2021 for 3 units). These claims are for encounter reporting purposes only and will not be reimbursed, per payment agreement in Attachment A.

1.15 Workforce Training. Provider shall ensure that all staff receive training as required in the Contract such as, but not limited to, Cultural Responsiveness, Implicit Bias, CLAS Standards, Trauma Informed Care, and uses of data to advance health equity to name a few. Provider and provider staff may access trainings offered by the PacificSource Training Program. For all other training, Provider shall have mechanisms in place that enable reporting to Health Plan, at Health Plan's reasonable request, details of training activities, annual training plans, training subjects, content outlines, objectives, target audiences, delivery system, evaluations, training hours, training attendance, and trainer qualifications. At a minimum, Provider shall provide Health Plan with an Annual Training and Education Report so that Health Plan may compile such information into Health Plan's report to the OHA.

2. PAYMENT.

Provider shall be paid for providing the Wraparound Work pursuant to Attachment A of the Agreement.

3. TERM AND TERMINATION.

This Addendum shall be in full force and effect for the Term of the Agreement, unless earlier terminated as provided herein. Either Party may terminate this Addendum, without impacting the Agreement, with the other Party's written consent, which shall not be unreasonably withheld.

4. DATA USE.

The Parties recognize and agree that it may be necessary to share certain data with each other that was not anticipated to give this Addendum its full force and effect. The Parties agree that they will meet and determine the exact data to provide, in accordance with the terms of this Addendum, as it becomes necessary. The additional specifications for that

data may be added as an amendment, at any time, to this Addendum as mutually agreed to by the Parties. The Parties acknowledge that the CCO Contract requires significant reporting to OHA, including documentation establishing compliance with OAR 309-019-0326, and agree to work together to ensure the proper completion and filing of such reports so that Health Plan may fulfill its obligations under the CCO Contract. Provider acknowledges that OHA will post many of the reports on its website. Where redaction of certain information is allowed, the Parties will coordinate on the identification of those redactions, although Health Plan will have the right to make the final redactions based on its sole discretion.

PacificSource Community Solutions

AMENDMENT TO

PacificSource / Marion County, a political subdivision of the State of Oregon

PARTICIPATING PROVIDER SERVICE AGREEMENT

Effective January 1, 2022 the PacificSource Participating Provider Service Agreement with Marion County, a political subdivision of the State of Oregon is amended as follows:

I. **Performance Measures** in Attachment A-2 dated effective 07/01/2022 shall be replaced with measure below dated effective 01/01/2022.

a. Assessments for Children in DHS Custody (2022 OHA Aligned Measure #29)	
Weighting	100%
Performance Monitoring	PacificSource reporting using PacificSource data, administrative claims only
Final Result	OHA 2022 Final QIM Results
Target	OHA Marion-Polk CCO 2022 Target
Population	Marion-Polk CCO Members
Measure Specification	OHA (QIM) Current Specification
Denominator	Per OHA (QIM) Current Specification

Except for the changes described herein, the Participating Provider Service Agreement remains unchanged.

PACIFICSOURCE HEALTH PLANS

By: _____
(Signature)

Peter McGarry
(Print or type name)

Title: Vice President – Provider Network

Date: 7/27/2022

MARION COUNTY, A POLITICAL SUBDIVISION OF THE STATE OF OREGON

By: DocuSigned by: Ryan Matthews 7D28A787656F458...
(Signature)

Ryan Matthews
(Print or type name)

Title: Administrator

Date: 7/25/2022

MARION COUNTY S

Authorized Signature: DocuSigned by: Jan Fritz DC16351248DE4EC... ive Officer — 7/26/2022 Date

Reviewed by Signature: DocuSigned by: Jane E Vetto D0CFC5B04B9F483... gal Counsel — 7/26/2022 Date

Reviewed by Signature: DocuSigned by: E4592AF8CAA542C... Marion County Contracts & Procurement — 7/25/2022 Date

AMENDMENT TO

PacificSource / Marion County, a political subdivision of the State of Oregon

PARTICIPATING PROVIDER SERVICE AGREEMENT

Effective January 01, 2021 the PacificSource Participating Provider Service Agreement with Marion County, a political subdivision of the State of Oregon is amended as follows:

I. **Effective 1/1/2021** Section 6.0 Performance Measures and Reporting (including sections 6.1 and 6.2) shall be deleted from **Attachment A-1** dated effective 1/1/2020.

Except for the changes described herein, the Participating Provider Service Agreement remains unchanged.

PACIFICSOURCE COMMUNITY SOLUTIONS

By: _____
(Signature)

Peter McGarry

Title: Vice President – Provider Network

Date: 7/27/2022

MARION COUNTY, A POLITICAL SUBDIVISION OF THE STATE OF OREGON

By: DocuSigned by: Ryan Matthews 7D28A787656F458...
(Signature)

Ryan Matthews
(Print or type name)

Title: Administrator

Date: 7/25/2022

MARION COUNTY S

Authorized Signature: DocuSigned by: Jan Fritz DC16351248DE4EC... 7/26/2022

tive Officer Date

Reviewed by Signature: DocuSigned by: Jane E Vetto D0CFC5B04B9F483... 7/26/2022

gal Counsel Date

Reviewed by Signature: DocuSigned by: E4592AF8CAA542C... 7/25/2022

Marion County Contracts & Procurement Date

PacificSource Community Solutions

AMENDMENT #7 TO

PacificSource / Marion County, a political subdivision of the State of Oregon

PARTICIPATING PROVIDER SERVICE AGREEMENT

Effective July 01, 2022 the PacificSource Participating Provider Service Agreement with Marion County, a political subdivision of the State of Oregon is amended as follows:

I. **Attachment A1** dated effective 01/01/2022 shall be replaced with **Amended Attachment A2** dated effective 07/01/2022.

Except for the changes described herein, the Participating Provider Service Agreement remains unchanged.

PACIFICSOURCE HEALTH PLANS

By: _____ (Signature)

Peter McGarry

Title: Vice President – Provider Network

Date: 6-14-22

MARION COUNTY, A POLITICAL SUBDIVISION OF THE STATE OF OREGON

DocuSigned by:
By: Ryan Matthews
7D28A787656F458...
(Signature)

Ryan Matthews
(Print or type name)

Title: Administrator

Date: 6/8/2022

MARION COUNTY SIGNATURE

Authorized Signature: DocuSigned by: Jan Fritz DC16351248DE4EC... 6/13/2022

Chief Administrative Officer Date

Reviewed by Signature: DocuSigned by: Jane E Vetto D0CFC5B04B9F483... 6/13/2022

Marion County Legal Counsel Date

Reviewed by Signature: DocuSigned by: E4592AF8CAA542C... 6/8/2022

Marion County Contracts & Procurement Date

Attachment A-2

Marion County, a political subdivision of the State of Oregon

July 1, 2022

Reimbursement Schedule – Risk/Incentive Model

Community Mental Health Program

1.0 Risk/Incentive Model

The 2022 Risk/Incentive model agreed upon by PacificSource and Provider, and to be implemented on July 1, 2022, shall contain the following:

(A) A risk/incentive model involving multiple community Health Care Budgets for populations of Members assigned to specific physical health primary care providers, derived from revenue allocated for the physical health and behavioral/chemical dependency health care needs of Members, and a settlement for providers with budget-based aligned incentives as indicated in this Attachment.

(B) Fee-for-service payment for professional services provided by Provider with a Claims Risk Withhold, in addition to program-based PMPM reimbursement where appropriate.

(C) For distinct OHP Member populations assigned to physical health primary providers with risk/incentive models in their agreements with PacificSource, a risk/incentive model which features Revenue and Expenses for physical health and behavioral health/chemical dependency professional and residential services under OHP and paid by the State of Oregon to PacificSource as a global capitation payment, and less revenue reductions pertaining to (i) ABA Therapy and Hepatitis C reconciliations (as reconciled with the State of Oregon if necessary), (ii) HRA adjustments, taxes, premium transfers and other OHA mandated premium reductions, and (iii) excluding Revenue and Expenses in the following categories:

State of Oregon mandated spending/expenses on social determinants of health.

"Dental Care" premium allocation and expenses until such time as this premium and expenses are added to risk model described here.

"Non-Emergent Medical Transportation" premium allocation and expenses.

CCO Quality Incentive Measure ("QIM") withhold return from the State of Oregon received in the year of settlement, whose distribution methodology is excluded as determined by the CCO Health Council.

Operating payments to the CCO Health Council, taxes, adjustments and premium transfers.

(D) Contract terms that are consistent with the Joint Management Agreement (JMA) and JMA budget signed between PacificSource and the CCO Health Council which specifies the rules, duties, obligation, limitations on PacificSource margin, "Health Services" allocations, and other obligations and expenses for PacificSource as a CCO.

(E) Metrics which specify the return of part or all of the Risk Withhold and Surplus which may result from health care expenses measured against a Health Care Budget.

2.0 Compensation

2.1 Fee For Service Reimbursement

SERVICE/PROCEDURE	MAXIMUM ALLOWABLE
Outpatient Behavioral Health Assessments: Codes listed below	**160%** of current OHP Allowable Amount[1, 2]
Evaluation and Management Services: Codes listed below	**160%** of current OHP Allowable Amount[1, 2]
Other Outpatient Mental Health Services: Codes listed below	**130%** of current OHP Allowable Amount[1, 2]
Other Outpatient Substance Use Disorder Services: Codes listed below	**130%** of current OHP Allowable Amount[1, 2]
Laboratory, DME/supplies	**100%** of current OHP Allowable Amount[1, 2]
Drugs, Injections, Vaccines, Immunizations	**100%** of current OHP Allowable Amount[1, 2]
Services and Procedures not otherwise listed in this Attachment	**100%** of current OHP Allowable Amount[1, 2] or, if no OHP Allowable Amount, PacificSource Community Solutions Default Fee Allowance[3]

[1] Payment will be based on the lesser of the billed amount or PacificSource rates in effect at the time service or supplies are rendered or provided as specified above.

[2] PacificSource will reimburse based on the rates published as of the date of adjudication.

[3] PacificSource utilizes industry standard publications and rate methods to supplement codes not established by the above noted methodologies.

Outpatient Behavioral Health Assessment codes: 90791, 90792, 96130-96137, H0001, H0031, H2000
Evaluation and Management Services: 99201-99205, 99211-99215, 99354, 99355, 99341-99345, 99347-99350
Other Outpatient Mental Health Services codes: 90785, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90846, 90847, 90849, 90853, 90882, 90887, 90889, 96150-96154, H0032, T1023, T2010, T2011
Other Outpatient Substance Use Disorder Services codes: H0002, H0004, H0005, H0006. H0020, H0022, H0033, T1006

Fee For Service Reimbursement – Traditional Healthcare Workers (THWs)

SERVICE/PROCEDURE	MAXIMUM ALLOWABLE
All Medical Services: As defined in the OHP Medical-Dental Fee Schedule	**100**% of current OHP Allowable Amounts [1,2]
Anesthesia: Service or supply with an ASA value	**100**% of current OHP Allowable Amounts [1,2,3]
Laboratory, DME/supplies	**100**% of current OHP Allowable Amounts [1,2]
Drugs, Injectables, Vaccines, Immunizations:	**100**% of current OHP Allowable Amounts [1,2]
Services and Procedures without an established unit value	PacificSource Community Solutions Default Fee Allowance[4]

NOTE: Payment will be based on the negotiated rates in effect at the time the services or supplies are rendered or provided as specified above. Payment will be the lesser of Providers billed charges or the Maximum Allowable indicated herein.

1. PacificSource will reimburse based on the rates published as of the date of adjudication.
2. Updates to the schedules noted above shall be updated in accordance with the state of Oregon, OHA and HSD.
3. ASA Basic Unit Value and annual updates as defined by the American Society of Anesthesiologists Relative Value Guide. Time units shall be based on 15 minute increments.
4. PacificSource utilizes industry standard publications and rate methods to supplement codes not established by the above noted methodologies.

2.2 Claims Risk Withhold

Claims payments to Provider for the services above shall have ten percent (10%) of the Allowed Compensation withheld as a Claims Risk Withhold.

2.3 **Program-Based Reimbursement**

Reimbursement for the services and programs defined below will be calculated as a per-member per-month (PMPM) payment of $7.22 PMPM based on full CCO (not county-specific) membership eligible for mental health benefits. Starting 1/1/2022, the PMPM payment will be made prospectively based on the rates listed below with retroactive reconciliation as described below completed by PacificSource based on quarterly Provider reports using PacificSource's reporting template.

Services and Programs	Unit of Measure	$ per Unit	Budgeted Units (not to exceed)	Estimated Annual Payment	Actual Payment PMPM
Local Public Health Authority Services					$0.31
Local Mental Health Authority Services (i.e. residential care coordination, civil					$0.12

Services and Programs	Unit of Measure	$ per Unit	Budgeted Units (not to exceed)	Estimated Annual Payment	Actual Payment PMPM
commitment, system coordination)					
Youth Fidelity Wraparound Program (inclusive of all services, including those subcontracted)	Per enrolled member per month	$1,110			
Assertive Community Treatment	Per enrolled member per month	$1,740			
Professional Supervision for Licensure	Per Supervision Session (60/45/30 minute increments), paid quarterly	60 = $435.55 45 = $295.89 30 = $200.65			
Community Support Services (CSS)* Total					$6.79
Total Program Support					**$7.22**

Allocation of payment for Community Support Services[4]					
Crisis (including Mobile)					$2.09
Supported Employment Education					$0.63
Early Psychosis including EASA					$0.63
SPMI Services					$0.74
Intensive Children's Services					$0.28
Her Place					$0.33
Other CSS: LEAD					$2.09

Services and Programs	Description, Conditions, and Reporting
Community Support Services (CSS)* Total	Allocation of Program Support payment across CSS will be calculated or recalculated during the third quarter of each calendar year based on Provider's prior fiscal year budget and actual financials. Reporting: Actual expenditures, enrollment, performance, and outcomes.
General	Reporting: Actual expenditures, unduplicated individual enrollment, performance, and outcomes in format provided by Health Plan. Any reporting for January 1 – June 30th due by August 31. Any reporting for July 1 – December 31 due by February 28.

Services and Programs	Description, Conditions, and Reporting
PacificSource MLR Reporting	Reporting: Actual expenditures, unduplicated individual enrollment, performance, and outcomes in format provided by Health Plan. Any reporting for January 1 – June 20th due by August 28. Any reporting for July 1 – December 31 due by February 28.
OHA MLR Reporting	This reporting pertains specifically to the Exhibit L Financial Reporting Supplemental SE. Provider shall submit to Health Plan a report for each clinic for the cost time period of January 1 – June 30 by July 31, using a format accepted by the OHA. Provider shall submit to Health Plan a report for each clinic for the cost year January 1 – December 31 by February 28, using a format accepted by the OHA. Provider shall submit to Health Plan a report for each clinic for the cost year January 1 – December 31 by February 28, using a format accepted by the OHA. Provider shall refer to the OHA CCO Contract Forms website at https://www.oregon.gov/oha/HSD/OHP/pages/cco-contract-forms.aspx for support. Any changes to reporting requirements set forth by OHA will supersede the above requirements.
Professional Supervision for Licensure	Description: Registered Associate is defined as an individual who has completed education requirements and registered with their respective licensing board as they complete clinical hours for licensure. To qualify for payment, Registered Associates must be employed by Provider and have entered into a board-approved supervisory agreement with Clinical Supervisor employed by Provider. Payment is calculated by estimating potential revenue lost due to Clinical Supervisor and Registered Associate not being able to bill for psychotherapy services during supervision time. Payment may be recouped if evidence of a supervision agreement between the Registered Associate and Clinical Supervisor is not provided. Reporting: On or before 15 days following quarter's end, Provider shall submit supervision log for supervision hours provided to Registered Associates. Annually (on or before January 15th), provider will submit roster of Registered Associates that Provider staff had supervision agreements with in prior year. Provider will include the supervision agreement for each Registered Associate listed.
Youth Fidelity Wraparound Program	Condition: Fidelity to OHA model Reporting: Monthly enrollment and enrollee encounters. On or before the 5th of the month, Provider shall send an invoice to PacificSource Community Solutions for invoicing purposes. This invoice shall indicate members served in a previous month and include the following data: - Member name - Member date of birth - Member identification number PacificSource shall verify member eligibility and coverage, prorating the monthly rate should the member have not been eligible for services for the entire month. Provider will submit additional data elements as determined by PacificSource in order to verify the services rendered and member eligibility.

Services and Programs	Description, Conditions, and Reporting
Assertive Community Treatment (ACT)	Reporting: Monthly enrollment and enrollee encounters. On or before the 5th of the month, Provider shall send an invoice to PacificSource Community Solutions for invoicing purposes. This invoice shall indicate members served in a previous month and include the following data: - Member name - Member date of birth - Member identification number PacificSource shall verify member eligibility and coverage, prorating the monthly rate should the member have not been eligible for services for the entire month. Provider will submit additional data elements as determined by PacificSource in order to verify the services rendered and member eligibility.
Marion County funding for community programs	Should Marion County discontinue any Community Mental Health Program services outlined in ORS 430.630 or referenced in section 2.3 of this Attachment A-1, PacificSource Community Solutions will be given 120 day notice.

The following codes will be encountered at 100% of OHP fee schedule or, when not listed on the OHP fee schedule, PacificSource Community Solutions Default Fee Allowance, but these codes will not be paid because their value is included in the Program payments detailed above:

Crisis	H2011, S9125, S9484
Training/Skills/Case Management	G0176, G0177, H0036, H0038, H0039, H0046, H2014, H2018, H2021, H2022, H2023, H2027, H2032, H2033, T1016
Medical services – within scope of nursing staff	H0034, H2010

2.4 Settlement Parameters

Provider understands and agrees to be subject to the settlement terms pertaining to Risk Withhold return and Surplus distribution, of other primary care provider agreements when providing services for OHP Members assigned to other primary care providers, and when providing services for OHP Members assigned to other primary care providers of other CCOs.

2.5 Surplus Distribution and Risk Withhold Return Contingent On Quality.

One hundred percent (100%) of any Surplus distribution and Provider's Risk Withhold return will be paid contingent on the Performance Measures as listed below and as negotiated on an annual, calendar year basis.

3.0 Premium Allocation

The following allocation of premium is part of the PacificSource budget-based aligned incentive structure:

3.1 Definition.

3.1.1 Estimated Earned Net Premium Revenue. Estimated Earned Net Premium Revenue shall be determined in the risk/incentive contract between PacificSource and the Member's assigned physical health primary care provider, but will generally consist of those global capitation payments (including adjustments) and reconciliations with the State of Oregon, received by PacificSource from the State of Oregon, less premium reductions in Section 1 which include: OHA-required Hepatitis C and ABA therapy reconciliation adjustments with the State of Oregon if necessary, OHA qualified and directed pass-through payments, Managed Care taxes, PacificSource income taxes, other state or federal taxes (HRA/GME/MCO/Provider), Hospital Reimbursement Adjustments (HRAs), Dual Eligible Medicare Premium Transfers, any OHA-mandated premium reductions, OHA-mandated Social Determinants of Health (SDOH) spending, Dental Care premium allocation to DCOs, Non-Emergent Transportation premium allocation, operating payments to CCO Health Council, and some portion of QIM risk withhold return per the agreement of the CCO Health Council.

3.2 Allocation of Estimated Earned Net Premium Revenue.

The remaining Estimated Earned Net Premium Revenue will be allocated as follows:

3.2.1 Administration. Eight and seventy hundredths percent (8.70%) of the remaining Estimated Earned Net Premium Revenue shall be allocated to PacificSource for administration and limited margin.

3.2.2 Amount Allocated to the Health Care Budget (HCB). Ninety-one and thirty hundredths percent (91.30%) of the remaining Estimated Earned Net Premium Revenue shall be allocated to the Health Care Budget.

4.0 Allocations and Disbursement

4.1 Computation of Budget Expenses.

Expenses will be determined in the risk/incentive model in the agreement between PacificSource and the Member's physical health primary care provider, but will generally include: All physical health and behavioral health claims expenses (including Risk Withhold), PMPM provider fees (including any PCPCH and CPC+ expenses), hospital/facility expenses, reinsurance/stop loss premium expenses (less recoveries), Pharmacy Expenses (less rebates), PCP Capitation Expense, subrogation adjustments, premium/MCO taxes, coinsurance expenses, out-of-area expenses, ancillary expenses, Traditional Healthcare Workers (THWs) expenses, Health Services and other expenses iterated in the Joint Management Agreement (JMA) and JMA budget between PacificSource and CCO, and Community Benefit and Flexible Services expenses shall be charged to the Health Care Budget based on the day services were actually rendered with the exception of Late Claims, as defined below, which shall be charged to the next year's applicable budget.

4.2 Disposition of Late Claims.

Late Claims are those claims received, processed, and paid later than four months (120 days) after the close of the contract period. Late Claims will be attributed to the next year's applicable budget.

5.0 Settlement Parameters

5.1 Settlement Parameters

The following settlement parameters for this section pertain for OHP members assigned to physical health primary care providers with risk/incentive models in their agreements with PacificSource. Provider understands and agrees to be subject to the settlement terms pertaining to surplus distribution and Risk Withhold return, of these other physical health provider agreements when providing services for OHP Members assigned to other providers, and assigned to other providers of other CCOs.

5.2 Time Period.

Annual Claims Risk Withhold settlement will occur for the calendar year four months (120 days) after the close of the contract period ending December 31st. Any charges/credits to the applicable budgets that have occurred since the settlement of the previous contract period are accounted for in the settlement of the current period. Claims Risk Withhold return will be mailed to Provider no later than forty-five (45) days after final OHA determinations of QIM revenue determinations and any OHA decisions on any revenue reductions which could be applied retroactively to the beginning of the contract period.

5.3 Claims Risk Withhold Settlement Summary.

PacificSource shall be responsible for computing, documenting, and reporting to Provider an annual Claims Risk Withhold settlement summary. This report shall be submitted to Provider approximately five months (151 days) after year-end.

5.4 Budget Surplus or Deficit

For the contract period for the experience of Members assigned to any physical health primary care provider with a risk/incentive model in their agreement with PacificSource, the Health Care Budget will be compared to actual expenses incurred to determine whether a Surplus or Deficit exists.

5.4.1 Surplus.

If the total value of total covered claims and expenses, including Claims Risk Withhold, is less than the HCB, a Surplus exists. Surplus distributions will be limited to a percentage of the Surplus amount. The non-distributed portion of Surplus will be treated as Shared Savings under the terms of the JMA. In the event of a Surplus payment, Surplus and Claims Risk Withhold may be returned to Provider depending on Quality Improvement Metric (QIM) performance. Surplus amounts may be distributed as a percentage depending on practitioner type, and amount of risk withhold accrued from Provider, with Provider's and any other provider's Surplus payment limited to three hundred percent (300%) of Provider's or any other provider's Risk Withhold amount.

5.4.2 Surplus Distribution and Risk Withhold Return Contingent On Quality.

One hundred percent (100%) of the surplus distribution and Risk Withhold return will be paid contingent on the performance of the CCO QIMs, the majority of which are established and measured by the State of Oregon for the entire CCO and will be awarded based on such State of Oregon measurement and State of Oregon final payment to PacificSource.

5.4.3 Surplus Distribution and Claims Risk Withhold Return – Value Based Payment.

Provider will cooperate with PacificSource in complying with OHA requirements for value-based payments in the areas of: Maternity, Hospital, Pediatric, Behavioral Health and Oral Health care. As such, Surplus Distribution and Claims Risk Withhold return may be contingent on a specific array of metrics pertaining to these OHA-required areas as determined by PacificSource and Provider.

5.4.4 Unearned Surplus and Risk Withhold

Any Unearned Risk Withhold and surplus shall be allocated in the following manner:

1st Used to contribute to PacificSource's limited margin, consistent with the limitation in the Joint Management Agreement (JMA) between PacificSource and the CCO Health Council.

2nd Any remaining Unearned Surplus Payment will be treated as shared savings under the terms of the JMA.

5.4.5 Deficit

If the value of total covered claims and expenses, including Claims Risk Withhold, is more than the Health Care Budget, a Deficit exists, and Claims Risk Withhold from all providers will be used to satisfy the Deficit, at an equal percentage from all providers. Any Claims Risk Withhold remaining after the Deficit has been reduced to zero dollars ($0.00) will be returned to providers as an equal percentage for all providers from whom Claims Risk Withhold was taken, consistent with performance of CCO QIMs. Any remaining Deficit after application of Claims Risk Withhold will be satisfied by PacificSource.

6.0 Performance Measures and Reporting

6.1 Performance Measures

For calendar year 2022, any Surplus and Risk Withhold Distribution to Provider shall be based on the below, with the weight of each performance measure representing the percentage of return to be paid based on achieving the measure.

6.2 Performance Reports.

Performance measure reports from Provider shall be submitted using PacificSource's ShareFile site by 11:59pm on the due date stated. Late submissions will incur a 25% penalty on weighted performance withhold value per partial or full week that reporting is submitted after the end of the grace period that ends two weeks after the due date.

a. Assessments for Children in DHS Custody (2021 OHA Aligned Measure #27)	
Weighting	11%
Performance Monitoring	PacificSource reporting using PacificSource data, administrative claims only
Final Result	OHA 2022 Final QIM Results
Target	OHA Marion-Polk CCO 2022 Target
Population	Marion-Polk CCO Members
Measure Specification	OHA (QIM) Current Specification
Denominator	Per OHA (QIM) Current Specification

7.0 GENERAL PROVISIONS.

7.1 Requirements

Provider will participate in and attest to performing (a) data submission activities pertinent to CCO eCQMs EHR-based incentive metrics, (b) data submission requirements including sending accurate data in time and formats determined by CCO to comply with OHA measure specifications, (c) submitting eCQM data to PacificSource on a monthly basis by the 20th of the month, (d) requests for surveys or other information, (e) requests to complete successful CCO data collection/submission activities, and (f) reporting expectations for eCQMs for diabetes, hypertension, depression, SBIRT, tobacco prevalence, BMI and any additional eCQM determined by OHA. Provider acknowledges that submission of these requirements is essential as failure to do so for each EHR-based incentive will lead to failure for each eCQM measure, failure to meet the population threshold required, and will cause the CCO to fail the measure.

Provider will perform patient satisfaction surveys in alignment with PCPCH standard requirements, and will share such survey results with PacificSource upon reasonable request.

Provider will cooperate with PacificSource on PacificSource's CAHPS Improvement Plans.

Provider allow PacificSource to share individual provider QIM performance with CCO Health Councils.

Provider will collaborate with PacificSource to gain consensus through the CCO Health Council on maximizing and distributing Quality Pool funds from OHA.

Provider will collaborate with PacificSource to comply with the OHA Health Plan Quality Metrics Committee (HPQMC), with PacificSource responsible for describing quality metrics from the HPQMC that will be used.

Provider will collaborate with PacificSource to comply with OHA's Practitioner Incentive Plan (PIP) reporting.

Provider will cooperate with PacificSource to collaborate on fulfilling any OHA requirements in the increased adoption of Health Information Exchange (HIE), Health Information Technology (HIT), and Electronic Health Record (EHR) technology.

7.2 Oregon Health Plan/OHA Capitation Administration Regulations

In the event of (a) new or changing requirements, rules, regulations or guidance related to applicable provider capitation payments made by PacificSource to Provider, and per PacificSource Exhibit L filing and Medical Loss Ratio filings submitted to OHA, and/or (b) PacificSource's and/or OHA's interpretation of applicability of such requirements, rules, regulations, or guidance and applicability of PacificSource's capitation payment methodology with Provider, PacificSource may enact the following:

- A charge commensurate with any OHA recoupment, demand for repayment, charge, tax or fee, to be charged against the CCO Health Care Budget, and/or
- A renegotiation with Provider to revert all payment methodologies entailing Provider capitation, to a fee-for-service payment methodology.

Provider shall cooperate with PacificSource to produce reports for PacificSource and/or OHA that satisfy to PacificSource and OHA discretion, the requirements, rules, regulations or guidance from OHA related to capitation payments.

7.3 Oregon Health Plan/OHA Possible Premium Revision / MLR-based repayment to OHA

In the event of a revision of premium levels for OHP members by the State of Oregon/OHA by a net amount deemed by PacificSource to be inconsistent with the reimbursement agreed to in this 2022 Agreement, PacificSource will notify Provider of such inconsistency in writing, and both parties will enter into a renegotiation of 2022 reimbursement rates to achieve consistency with any new Oregon PacificSource/OHA premium levels.

In the event OHA determines PacificSource must pay OHA any sum because the CCO Medical Loss Ratio (MLR), as determined by OHA, does not meet a minimum threshold for the entire population or any benefit-category specific sub populations, PacificSource reserves the right to (a) deduct a pro-rata portion of such repayment from the Health Care Budget in Section 6, or (b) make direct investments to increase the MLR and offset such expenses with the settlement, upon communication with Provider and the CCO Health Council.

7.4 Health Related Services (Flexible Services and Community Based Health-Related Services.

Consistent with the Health-Related Services Rule adopted by the OHA (which include member-level disbursements often called "flexible services", and community-based Health-Related Services, often called "Community Benefit Initiatives") and the Health-Related Services Brief released by the OHA, along with PacificSource policies approved by OHA, PacificSource will make certain disbursements from the Health Care Budgets from time to time and at PacificSource's discretion. These disbursements are distinct from PacificSource-provided Health Services.

7.5 Community Health Improvement Plan, Transformation Plan and Health Council Activities.

Provider will collaborate with PacificSource, the CCO Health Council, and other stakeholders in completing a Community Health Assessment (CHA) and a Community Health Improvement Plan (CHIP), and in carrying out activities to implement the CHIP including any recommendation tied to community access studies. Provider will

collaborate with PacificSource, the CCO Health Council, and other stakeholders to carry out the Transformation And Quality Strategies. For purposes of the CHA, CHIP, or Transformation And Quality Strategies, for reporting to the CCO Health Council or any of its subcommittees, or for reporting to OHA, PacificSource may share Provider utilization, membership numbers, and additional performance data. Provider will collaborate with PacificSource and the CCO Health Council to meet Transformation And Quality Strategies requirements and participate in Transformation And Quality Strategy projects.

7.7 Corrective Action Plans

PacificSource, at its sole discretion and consistent with expectations of PacificSource by OHA, may determine that Provider performance of obligations, duties and responsibilities under the terms of this Agreement is deficient. In reaching that conclusion, PacificSource may, but is not required to consider third-party audit or other formal review results, peer review results, quality measures, written or oral feedback from members or patients, and any other issues which may be identified by PacificSource. If PacificSource determines Provider performance is deficient for any reason, but that such deficiency does not constitute a Material Breach of the terms of this Agreement, PacificSource may institute a corrective action plan ("CAP") subject to internal review. PacificSource will notify Provider of the terms of the CAP and will provide a CAP reporting template. PacificSource will supply supporting information/data to Provider at that time. Provider shall have thirty (30) days to resolve the CAP to PacificSource's satisfaction. Failure to resolve the CAP shall constitute a Material Breach by Provider, and PacificSource may terminate this Agreement immediately.

7.8 Value-Based Payment

Provider agrees to participate in PacificSource's Value-Based Payment (VBP) program, consistent with OHA requirements for the five year period from 2020-2024 in which an increasing portion of provider payment conforms to the Learning and Action Network (LAN) category 2C or higher, which may entail the following elements.

- Payment based on any of the above methodologies
- Payment Withhold
- Surplus sharing
- Payment models to support care transformation and quality improvement in the following areas:

  Hospital Care
  Maternity Care
  Children's Care
  Behavioral Health Care
  Oral Health Care

In collaboration with Provider, PacificSource will share with Provider information pertaining to Health Information Technology (HIT) to support success in effective participation with the VBP program.

8.0 Miscellaneous

8.1 Defined Terms

Any terms not otherwise defined herein shall have the meaning set forth in the Participating Provider Agreement.

8.2 Precedence

Any conflict or inconsistency shall be resolved by giving precedence to this Attachment first, then to Attachment B, and then to the Participating Provider Agreement.

PacificSource
Community Solutions

AMENDMENT #6 TO

PacificSource / Marion County, a political subdivision of the State of Oregon

PARTICIPATING PROVIDER SERVICE AGREEMENT

Effective January 01, 2022 the PacificSource Participating Provider Service Agreement with Marion County, a political subdivision of the State of Oregon is amended as follows:

I. **Attachment A-1** dated effective 4/1/2020 shall be replaced with **Amended Attachment A-1** dated effective 01/01/2022.
II. **Wraparound Addendum** dated effective 01/01/2022 shall be added to agreement.

Except for the changes described herein, the Participating Provider Service Agreement remains unchanged.

PACIFICSOURCE HEALTH PLANS

By: _____
(Signature)

Peter McGarry

Title: Vice President – Provider Network

Date: 12-30-21

MARION COUNTY, A POLITICAL SUBDIVISION OF THE STATE OF OREGON

By: _____
(Signature)

Ryan Matthews
(Print or type name)

Title: Administrator

Date: 12/17/2021

MARION COUNTY SIGNATURE
BOARD OF COMMISSIONERS:

Chair — Date: 12.29.2021

Commissioner — Date

Commissioner — Date: 12/29/2021

Authorized Signature: _____ 12/27/21
Chief Administrative Officer — Date

Reviewed by Signature: _____
Marion County Legal Counsel — Date

Reviewed by Signature: _____ 12/17/21
Marion County Contracts & Procurement — Date

Attachment A-1

Marion County, a political subdivision of the State of Oregon

January 1, 2022

Reimbursement Schedule – Risk/Incentive Model

Community Mental Health Program

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[2] PacificSource will reimburse based on the rates published as of the date of adjudication.

[3] PacificSource utilizes industry standard publications and rate methods to supplement codes not established by the above noted methodologies.

Outpatient Behavioral Health Assessment codes: 90791, 90792, 96130-96137, H0001, H0031, H2000
Evaluation and Management Services: 99201-99205, 99211-99215, 99354, 99355, 99341-99345, 99347-99350
Other Outpatient Mental Health Services codes: 90785, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90846, 90847, 90849, 90853, 90882, 90887, 90889, 96150-96154, H0032, T1023, T2010, T2011
Other Outpatient Substance Use Disorder Services codes: H0002, H0004, H0005, H0006. H0020, H0022, H0033, T1006

Fee For Service Reimbursement – Traditional Healthcare Workers (THWs)

SERVICE/PROCEDURE	MAXIMUM ALLOWABLE
All Medical Services: As defined in the OHP Medical-Dental Fee Schedule	**100**% of current OHP Allowable Amounts [1,2]
Anesthesia: Service or supply with an ASA value	**100**% of current OHP Allowable Amounts [1,2,3]
Laboratory, DME/supplies	**100**% of current OHP Allowable Amounts [1,2]
Drugs, Injectables, Vaccines, Immunizations:	**100**% of current OHP Allowable Amounts [1,2]
Services and Procedures without an established unit value	PacificSource Community Solutions Default Fee Allowance[4]

NOTE: Payment will be based on the negotiated rates in effect at the time the services or supplies are rendered or provided as specified above. Payment will be the lesser of Providers billed charges or the Maximum Allowable indicated herein.

1. PacificSource will reimburse based on the rates published as of the date of adjudication.
2. Updates to the schedules noted above shall be updated in accordance with the state of Oregon, OHA and HSD.
3. ASA Basic Unit Value and annual updates as defined by the American Society of Anesthesiologists Relative Value Guide. Time units shall be based on 15 minute increments.
4. PacificSource utilizes industry standard publications and rate methods to supplement codes not established by the above noted methodologies.

2.2 Claims Risk Withhold

Claims payments to Provider for the services above shall have ten percent (10%) of the Allowed Compensation withheld as a Claims Risk Withhold.

2.3 **Program-Based Reimbursement**

Reimbursement for the services and programs defined below will be calculated as a per-member per-month (PMPM) payment of $7.22 PMPM based on full CCO (not county-specific) membership eligible for mental health benefits. Starting 1/1/2022, the PMPM payment will be made prospectively based on the rates listed below with retroactive reconciliation as described below completed by PacificSource based on quarterly Provider reports using PacificSource's reporting template.

Services and Programs	Unit of Measure	$ per Unit	Budgeted Units (not to exceed)	Estimated Annual Payment	Actual Payment PMPM
Local Public Health Authority Services					$0.31
Local Mental Health Authority Services (i.e. residential care coordination, civil					$0.12

Services and Programs	Unit of Measure	$ per Unit	Budgeted Units (not to exceed)	Estimated Annual Payment	Actual Payment PMPM
commitment, system coordination)					
Youth Fidelity Wraparound Program (inclusive of all services, including those subcontracted)	Per member per month	$1,110			
Assertive Community Treatment	Per member per month	$1,740			
Professional Supervision for Licensure	Per Supervision Session (60/45/30 minute increments), paid quarterly	60 = $435.55 45 = $295.89 30 = $200.65			
Community Support Services (CSS)* Total					$6.79
Total Program Support					**$7.22**

Allocation of payment for Community Support Services[4]					
Crisis (including Mobile)					$2.09
Supported Employment Education					$0.63
Early Psychosis including EASA					$0.63
SPMI Services					$0.74
Intensive Children's Services					$0.28
Her Place					$0.33
Other CSS: LEAD					$2.09

Services and Programs	Description, Conditions, and Reporting
Community Support Services (CSS)* Total	Allocation of Program Support payment across CSS will be calculated or recalculated during the third quarter of each calendar year based on Provider's prior fiscal year budget and actual financials. Reporting: Actual expenditures, enrollment, performance, and outcomes.

Services and Programs	Description, Conditions, and Reporting
Professional Supervision for Licensure	Description: Registered Associate is defined as an individual who has completed education requirements and registered with their respective licensing board as they complete clinical hours for licensure. To qualify for payment, Registered Associates must be employed by Provider and have entered into a board-approved supervisory agreement with Clinical Supervisor employed by Provider. Payment is calculated by estimating potential revenue lost due to Clinical Supervisor and Registered Associate not being able to bill for psychotherapy services during supervision time. Payment may be recouped if evidence of a supervision agreement between the Registered Associate and Clinical Supervisor is not provided. Reporting: On or before 15 days following quarter's end, Provider shall submit supervision log for supervision hours provided to Registered Associates. Annually (on or before January 15th), provider will submit roster of Registered Associates that Provider staff had supervision agreements with in prior year. Provider will include the supervision agreement for each Registered Associate listed.
Youth Fidelity Wraparound Program	Condition: Fidelity to OHA model Reporting: Monthly enrollment and enrollee encounters. On or before the 5th of the month, Provider shall send an invoice to PacificSource Community Solutions for invoicing purposes. This invoice shall indicate members served in a previous month and include the following data: - Member name - Member date of birth - Member identification number PacificSource shall verify member eligibility and coverage, prorating the monthly rate should the member have not been eligible for services for the entire month. Provider will submit additional data elements as determined by PacificSource in order to verify the services rendered and member eligibility.
Assertive Community Treatment (ACT)	Reporting: Monthly enrollment and enrollee encounters. On or before the 5th of the month, Provider shall send an invoice to PacificSource Community Solutions for invoicing purposes. This invoice shall indicate members served in a previous month and include the following data: - Member name - Member date of birth - Member identification number PacificSource shall verify member eligibility and coverage, prorating the monthly rate should the member have not been eligible for services for the entire month. Provider will submit additional data elements as determined by PacificSource in order to verify the services rendered and member eligibility.
Marion County funding for community programs	Should Marion County discontinue any Community Mental Health Program services outlined in ORS 430.630 or referenced in section 2.3 of this Attachment A-1, PacificSource Community Solutions will be given 120 day notice.

The following codes will be encountered at 100% of OHP fee schedule or, when not listed on the OHP fee schedule, PacificSource Community Solutions Default Fee Allowance, but these codes will not be paid because their value is included in the Program payments detailed above:

Crisis	H2011, S9125, S9484
Training/Skills/Case Management	G0176, G0177, H0036, H0038, H0039, H0046, H2014, H2018, H2021, H2022, H2023, H2027, H2032, H2033, T1016
Medical services – within scope of nursing staff	H0034, H2010

2.4 Settlement Parameters

Provider understands and agrees to be subject to the settlement terms pertaining to Risk Withhold return and Surplus distribution, of other primary care provider agreements when providing services for OHP Members assigned to other primary care providers, and when providing services for OHP Members assigned to other primary care providers of other CCOs.

2.5 Surplus Distribution and Risk Withhold Return Contingent On Quality.

One hundred percent (100%) of any Surplus distribution and Provider's Risk Withhold return will be paid contingent on the Performance Measures as listed below and as negotiated on an annual, calendar year basis.

3.0 Premium Allocation

The following allocation of premium is part of the PacificSource budget-based aligned incentive structure:

3.1 Definition.

3.1.1 Estimated Earned Net Premium Revenue. Estimated Earned Net Premium Revenue shall be determined in the risk/incentive contract between PacificSource and the Member's assigned physical health primary care provider, but will generally consist of those global capitation payments (including adjustments) and reconciliations with the State of Oregon, received by PacificSource from the State of Oregon, less premium reductions in Section 1 which include: OHA-required Hepatitis C and ABA therapy reconciliation adjustments with the State of Oregon if necessary, OHA qualified and directed pass-through payments, Managed Care taxes, PacificSource income taxes, other state or federal taxes (HRA/GME/MCO/Provider), Hospital Reimbursement Adjustments (HRAs), Dual Eligible Medicare Premium Transfers, any OHA-mandated premium reductions, OHA-mandated Social Determinants of Health (SDOH) spending, Dental Care premium allocation to DCOs, Non-Emergent Transportation premium allocation, operating payments to CCO Health Council, and some portion of QIM risk withhold return per the agreement of the CCO Health Council.

3.2 Allocation of Estimated Earned Net Premium Revenue.

The remaining Estimated Earned Net Premium Revenue will be allocated as follows:

3.2.1 Administration. Eight and seventy hundredths percent (8.70%) of the remaining Estimated Earned Net Premium Revenue shall be allocated to PacificSource for administration and limited margin.

3.2.2 Amount Allocated to the Health Care Budget (HCB). Ninety-one and thirty hundredths percent (91.30%) of the remaining Estimated Earned Net Premium Revenue shall be allocated to the Health Care Budget.

4.0 Allocations and Disbursement

4.1 Computation of Budget Expenses.

Expenses will be determined in the risk/incentive model in the agreement between PacificSource and the Member's physical health primary care provider, but will generally include: All physical health and behavioral health claims expenses (including Risk Withhold), PMPM provider fees (including any PCPCH and CPC+ expenses), hospital/facility expenses, reinsurance/stop loss premium expenses (less recoveries), Pharmacy Expenses (less rebates), PCP Capitation Expense, subrogation adjustments, premium/MCO taxes, coinsurance expenses, out-of-area expenses, ancillary expenses, Traditional Healthcare Workers (THWs) expenses, Health Services and other expenses iterated in the Joint Management Agreement (JMA) and JMA budget between PacificSource and CCO, and Community Benefit and Flexible Services expenses shall be charged to the Health Care Budget based on the day services were actually rendered with the exception of Late Claims, as defined below, which shall be charged to the next year's applicable budget.

4.2 Disposition of Late Claims.

Late Claims are those claims received, processed, and paid later than four months (120 days) after the close of the contract period. Late Claims will be attributed to the next year's applicable budget.

5.0 Settlement Parameters

5.1 Settlement Parameters

The following settlement parameters for this section pertain for OHP members assigned to physical health primary care providers with risk/incentive models in their agreements with PacificSource. Provider understands and agrees to be subject to the settlement terms pertaining to surplus distribution and Risk Withhold return, of these other physical health provider agreements when providing services for OHP Members assigned to other providers, and assigned to other providers of other CCOs.

5.2 Time Period.

Annual Claims Risk Withhold settlement will occur for the calendar year four months (120 days) after the close of the contract period ending December 31st. Any charges/credits to the applicable budgets that have occurred since the settlement of the previous contract period are accounted for in the settlement of the current period. Claims Risk Withhold return will be mailed to Provider no later than forty-five (45) days after final OHA determinations of QIM revenue determinations and any OHA decisions on any revenue reductions which could be applied retroactively to the beginning of the contract period.

5.3 Claims Risk Withhold Settlement Summary.

PacificSource shall be responsible for computing, documenting, and reporting to Provider an annual Claims Risk Withhold settlement summary. This report shall be submitted to Provider approximately five months (151 days) after year-end.

5.4 Budget Surplus or Deficit

For the contract period for the experience of Members assigned to any physical health primary care provider with a risk/incentive model in their agreement with PacificSource, the Health Care Budget will be compared to actual expenses incurred to determine whether a Surplus or Deficit exists.

5.4.1 Surplus.

If the total value of total covered claims and expenses, including Claims Risk Withhold, is less than the HCB, a Surplus exists. Surplus distributions will be limited to a percentage of the Surplus amount. The non-distributed portion of Surplus will be treated as Shared Savings under the terms of the JMA. In the event of a Surplus payment, Surplus and Claims Risk Withhold may be returned to Provider depending on Quality Improvement Metric (QIM) performance. Surplus amounts may be distributed as a percentage depending on practitioner type, and amount of risk withhold accrued from Provider, with Provider's and any other provider's Surplus payment limited to three hundred percent (300%) of Provider's or any other provider's Risk Withhold amount.

5.4.2 Surplus Distribution and Risk Withhold Return Contingent On Quality.

One hundred percent (100%) of the surplus distribution and Risk Withhold return will be paid contingent on the performance of the CCO QIMs, the majority of which are established and measured by the State of Oregon for the entire CCO and will be awarded based on such State of Oregon measurement and State of Oregon final payment to PacificSource.

5.4.3 Surplus Distribution and Claims Risk Withhold Return – Value Based Payment.

Provider will cooperate with PacificSource in complying with OHA requirements for value-based payments in the areas of: Maternity, Hospital, Pediatric, Behavioral Health and Oral Health care. As such, Surplus Distribution and Claims Risk Withhold return may be contingent on a specific array of metrics pertaining to these OHA-required areas as determined by PacificSource and Provider.

5.4.4 Unearned Surplus and Risk Withhold

Any Unearned Risk Withhold and surplus shall be allocated in the following manner:

1st Used to contribute to PacificSource's limited margin, consistent with the limitation in the Joint Management Agreement (JMA) between PacificSource and the CCO Health Council.

2nd Any remaining Unearned Surplus Payment will be treated as shared savings under the terms of the JMA.

5.4.5 Deficit

If the value of total covered claims and expenses, including Claims Risk Withhold, is more than the Health Care Budget, a Deficit exists, and Claims Risk Withhold from all providers will be used to satisfy the Deficit, at an equal percentage from all providers. Any Claims Risk Withhold remaining after the Deficit has been reduced to zero dollars ($0.00) will be returned to providers as an equal percentage for all providers from whom Claims Risk Withhold was taken, consistent with performance of CCO QIMs. Any remaining Deficit after application of Claims Risk Withhold will be satisfied by PacificSource.

6.0 Performance Measures and Reporting

6.1 Performance Measures

For calendar year 2022, any Surplus and Risk Withhold Distribution to Provider shall be based on the below, with the weight of each performance measure representing the percentage of return to be paid based on achieving the measure.

6.2 Performance Reports.

Performance measure reports from Provider shall be submitted using PacificSource's ShareFile site by 11:59pm on the due date stated. Late submissions will incur a 25% penalty on weighted performance withhold value per partial or full week that reporting is submitted after the end of the grace period that ends two weeks after the due date.

a. Assessments for Children in DHS Custody (2021 OHA Aligned Measure #27)	
Weighting	11%
Performance Monitoring	PacificSource reporting using PacificSource data, administrative claims only
Final Result	OHA 2022 Final QIM Results
Target	OHA Marion-Polk CCO 2022 Target
Population	Marion-Polk CCO Members
Measure Specification	OHA (QIM) Current Specification
Denominator	Per OHA (QIM) Current Specification

7.0 GENERAL PROVISIONS.

7.1 Requirements

Provider will participate in and attest to performing (a) data submission activities pertinent to CCO eCQMs EHR-based incentive metrics, (b) data submission requirements including sending accurate data in time and formats determined by CCO to comply with OHA measure specifications, (c) submitting eCQM data to PacificSource on a monthly basis by the 20th of the month, (d) requests for surveys or other information, (e) requests to complete successful CCO data collection/submission activities, and (f) reporting expectations for eCQMs for diabetes, hypertension, depression, SBIRT, tobacco prevalence, BMI and any additional eCQM determined by OHA. Provider acknowledges that submission of these requirements is essential as failure to do so for each EHR-based incentive will lead to failure for each eCQM measure, failure to meet the population threshold required, and will cause the CCO to fail the measure.

Provider will perform patient satisfaction surveys in alignment with PCPCH standard requirements, and will share such survey results with PacificSource upon reasonable request.

Provider will cooperate with PacificSource on PacificSource's CAHPS Improvement Plans.

Provider allow PacificSource to share individual provider QIM performance with CCO Health Councils.

Provider will collaborate with PacificSource to gain consensus through the CCO Health Council on maximizing and distributing Quality Pool funds from OHA.

Provider will collaborate with PacificSource to comply with the OHA Health Plan Quality Metrics Committee (HPQMC), with PacificSource responsible for describing quality metrics from the HPQMC that will be used.

Provider will collaborate with PacificSource to comply with OHA's Practitioner Incentive Plan (PIP) reporting.

Provider will cooperate with PacificSource to collaborate on fulfilling any OHA requirements in the increased adoption of Health Information Exchange (HIE), Health Information Technology (HIT), and Electronic Health Record (EHR) technology.

7.2 Oregon Health Plan/OHA Capitation Administration Regulations

In the event of (a) new or changing requirements, rules, regulations or guidance related to applicable provider capitation payments made by PacificSource to Provider, and per PacificSource Exhibit L filing and Medical Loss Ratio filings submitted to OHA, and/or (b) PacificSource's and/or OHA's interpretation of applicability of such requirements, rules, regulations, or guidance and applicability of PacificSource's capitation payment methodology with Provider, PacificSource may enact the following:

- A charge commensurate with any OHA recoupment, demand for repayment, charge, tax or fee, to be charged against the CCO Health Care Budget, and/or
- A renegotiation with Provider to revert all payment methodologies entailing Provider capitation, to a fee-for-service payment methodology.

Provider shall cooperate with PacificSource to produce reports for PacificSource and/or OHA that satisfy to PacificSource and OHA discretion, the requirements, rules, regulations or guidance from OHA related to capitation payments.

7.3 Oregon Health Plan/OHA Possible Premium Revision / MLR-based repayment to OHA

In the event of a revision of premium levels for OHP members by the State of Oregon/OHA by a net amount deemed by PacificSource to be inconsistent with the reimbursement agreed to in this 2022 Agreement, PacificSource will notify Provider of such inconsistency in writing, and both parties will enter into a renegotiation of 2022 reimbursement rates to achieve consistency with any new Oregon PacificSource/OHA premium levels.

In the event OHA determines PacificSource must pay OHA any sum because the CCO Medical Loss Ratio (MLR), as determined by OHA, does not meet a minimum threshold for the entire population or any benefit-category specific sub populations, PacificSource reserves the right to (a) deduct a pro-rata portion of such repayment from the Health Care Budget in Section 6, or (b) make direct investments to increase the MLR and offset such expenses with the settlement, upon communication with Provider and the CCO Health Council.

7.4 MLR Reporting for 2022.

Provider shall submit to PacificSource a report for each clinic for the cost year January 1, 2022 – December 31, 2022 no later than March 30, 2023 using a format accepted by OHA. Provider shall refer to "2020 Medical Loss Ratio Rebate Instructions" (as published on the OHA CCO Contract Forms website at http://www.oregon.gov/oha/healthplan/Pages/cco-contract-forms.aspx) for support.

7.5 Health Related Services (Flexible Services and Community Based Health-Related Services.

Consistent with the Health-Related Services Rule adopted by the OHA (which include member-level disbursements often called "flexible services", and community-based Health-Related Services, often called "Community Benefit Initiatives") and the Health-Related Services Brief released by the OHA, along with PacificSource policies approved by OHA, PacificSource will make certain disbursements from the Health Care Budgets from time to time and at PacificSource's discretion. These disbursements are distinct from PacificSource-provided Health Services.

7.6 Community Health Improvement Plan, Transformation Plan and Health Council Activities.

Provider will collaborate with PacificSource, the CCO Health Council, and other stakeholders in completing a Community Health Assessment (CHA) and a Community Health Improvement Plan (CHIP), and in carrying out activities to implement the CHIP including any recommendation tied to community access studies. Provider will collaborate with PacificSource, the CCO Health Council, and other stakeholders to carry out the Transformation And Quality Strategies. For purposes of the CHA, CHIP, or Transformation And Quality Strategies, for reporting to the CCO Health Council or any of its subcommittees, or for reporting to OHA, PacificSource may share Provider utilization, membership numbers, and additional performance data. Provider will collaborate with PacificSource and the CCO Health Council to meet Transformation And Quality Strategies requirements and participate in Transformation And Quality Strategy projects.

7.7 Corrective Action Plans

PacificSource, at its sole discretion and consistent with expectations of PacificSource by OHA, may determine that Provider performance of obligations, duties and responsibilities under the terms of this Agreement is deficient. In reaching that conclusion, PacificSource may, but is not required to consider third-party audit or other formal review results, peer review results, quality measures, written or oral feedback from members or patients, and any other issues which may be identified by PacificSource. If PacificSource determines Provider performance is deficient for any reason, but that such deficiency does not constitute a Material Breach of the terms of this Agreement, PacificSource may institute a corrective action plan ("CAP") subject to internal review. PacificSource will notify Provider of the terms of the CAP and will provide a CAP reporting template. PacificSource will supply supporting information/data to Provider at that time. Provider shall have thirty (30) days to resolve the CAP to PacificSource's satisfaction. Failure to resolve the CAP shall constitute a Material Breach by Provider, and PacificSource may terminate this Agreement immediately.

7.8 Value-Based Payment

Provider agrees to participate in PacificSource's Value-Based Payment (VBP) program, consistent with OHA requirements for the five year period from 2020-2024 in which an

increasing portion of provider payment conforms to the Learning and Action Network (LAN) category 2C or higher, which may entail the following elements.

- Payment based on any of the above methodologies
- Payment Withhold
- Surplus sharing
- Payment models to support care transformation and quality improvement in the following areas:

  Hospital Care
  Maternity Care
  Children's Care
  Behavioral Health Care
  Oral Health Care

In collaboration with Provider, PacificSource will share with Provider information pertaining to Health Information Technology (HIT) to support success in effective participation with the VBP program.

8.0 Miscellaneous

8.1 Defined Terms

Any terms not otherwise defined herein shall have the meaning set forth in the Participating Provider Agreement.

8.2 Precedence

Any conflict or inconsistency shall be resolved by giving precedence to this Attachment first, then to Attachment B, and then to the Participating Provider Agreement.

ADDENDUM

Marion County, a political subdivision of the State of Oregon

01/01/2022

Youth Fidelity Wraparound

RECITALS

A. Wraparound is an intensive care coordination process for youth with emotional and behavioral disorders who are involved in multiple systems. These systems include, but are not limited to, mental health, addictions, child welfare, intellectual or developmental disabilities, juvenile justice, and education. Wraparound is a team-based, strengths-based process that organizes a youth-and-family-driven system of services and supports. Services and supports are individualized for a youth and family to achieve a positive set of outcomes.

B. Provider is committed to participating in supporting the continuum of care that integrates health services by means of implementing a System of Care approach that includes models such as Wraparound for children with behavioral health disorders.

C. Provider serves as a Wraparound Provider or supports multiple Wraparound Providers, and Provider specializes in providing Wraparound supports to eligible Members in accordance with OAR 309-019-0326. Provider delivers Wraparound supports pursuant to Fidelity Wraparound requirements, as required by OAR 309-019-0326 and Exhibit M of the CCO Contract.

1. WRAPAROUND WORK.

Provider retains Provider to create, support, and manage the services for its Members in the Service Area as described and in accordance with this Section 1 (the "Wraparound Work"). Provider agrees to render all Wraparound Work in accordance with the terms and conditions of the Agreement and this Attachment, applicable state and federal law, applicable government regulations and guidance, and in conformity with appropriate and accepted standards of care for those services. Nothing herein is intended to create, and shall not create, any exclusive arrangement between Provider and Provider. This Agreement shall not restrict either Party from acquiring similar, equal or like goods or services from other entities or sources. The Parties acknowledge that there may be changes in OHA guidance or interpretation in the future that impact this Agreement. The Parties agree to work together to adjust and incorporate such OHA guidance and interpretations into this Agreement and/or into the work performed hereunder, as well as any new requirements from an amendment to the CCO Contract or as otherwise required by OHA. Provider shall perform Wraparound Work, as described in greater detail below:

1.1 Wraparound Services. Provider shall administer Wraparound care coordination services to Fidelity, consistent with the obligations specifically related to Wraparound services set forth in OAR 309-019-0326 and Exhibit M of the CCO Contract. In particular, Provider shall:

- Ensure certified providers administer the Child and Adolescent Needs and Strengths Assessment ("CANS") Oregon to members, consistent with the requirements set forth in Exhibit M of the CCO Contract, including input of CANS data into state data system. All staff administering the CANS must be certified by the Praed Foundation;
- Ensure its providers and staff are trained in integration and foundations of Trauma Informed Care, recovery principles, motivational interviewing, assessing for Adverse Childhood Experiences, and rendering services in a Culturally and Linguistically Appropriate manner;
- Adhere to applicable elements of the System of Care Wraparound Initiative Guidance Document published by the OHA; and
- Complete required documents for each enrolled youth and their family pursuant to the Fidelity model.
- Wraparound Input member information into state's Fidelity and Monitoring System, WrapStat, including: Medicaid ID numbers, Wraparound enrollments, discharges, and member demographic information.
- Distribute WFI-EZs according to the evaluation cycles identified in WrapStat, ensuring all youth and members of their Wraparound team who are a part of the evaluation cycle are provided the opportunity to complete a WFI-EZ. WFI-EZs can be collected electronically through WrapStat or in hard copy format, with all paper copies required to be submitted to Health Plan for entry into WrapStat.
- Complete TOMs during evaluation cycles identified in WrapStat.

1.2 Clients Served. Provider shall be reimbursed for the number of Wraparound clients served each month. Provider will be responsible for invoicing PacificSource on a monthly basis to indicate youth enrolled in Wraparound program.

1.3 PacificSource's Wraparound Policies. Provider agrees to comply with Health Plan's Wraparound policies and procedures, including those policies and procedures specifically related to Wraparound services described in Exhibit M of the CCO Contract. Provider also agrees to provide feedback not less than annually in order to support Health Plan in improving its policies and procedures to meet the needs of the local community.

1.4 Wraparound Staff. Provider will ensure the implementation of Fidelity Wraparound by hiring and training the following staff required in Exhibit M to deliver Wraparound Work:

- Wraparound Care Coordinator;
- Wraparound Supervisor;
- Wraparound Coach;
- Youth Peer Delivered Service Provider;
- Family Peer Delivered Service Provider; and
- Peer Delivered Service Provider Supervisor.

1.5 **Workforce.** On not less than a quarterly basis, Provider agrees to share with Health Plan a summary of its workforce, including whether any of its employed or contracted workforce are certified or grandfathered as traditional health workers, as well as their corresponding scope of practice using a THW reporting template supplied by Health Plan. This information is required by the OHA, and allows the Health Plan to develop targeted strategies to meet member health needs. After Provider produces this analysis, the Parties agree to meet and review the analysis to discuss barriers and opportunities.

1.6 **Assistance in Meeting OHA Obligations.** Provider agrees to cooperate with and assist PacificSource in fulfilling PacificSource's obligations to the OHA with regard to services performed under this Agreement. Notwithstanding the foregoing, nothing in this Attachment will require Provider to provide oral health or physical health interventions unless otherwise agreed to by the parties.

1.7 **Behavioral Health Report.** Provider agrees to collaborate with Health Plan to complete reporting to the OHA, including the Behavioral Health Report that Health Plan must submit to the OHA on an annual basis.

1.8 **Wraparound Collaboration.** Provider agrees to work collaboratively with Health Plan staff, as reasonably requested. Provider also agrees to participate in technical assistance offered by Health Plan, including training in trauma-informed care principles.

1.9 **Participation in System of Care Governance.** Provider agrees to participate in System of Care work groups, including the Practice Level Workgroup, to support a comprehensive, person-centered, individualized, and integrated community-based array of child and youth behavioral health services using System of Care principles.

1.10 **Participation in Community Governance.** Provider agrees to participate in the local Community Health Assessment and Community Health Improvement Plan, as may be requested by Health Plan from time to time. In addition, Provider agrees to participate in the Community Advisory Council to share valuable perspectives with the community.

1.11 **Caseloads.** Provider shall track the ratio of care coordinators, family support specialists, and youth support specialists to families served. Provider shall maintain adequate staffing in order to ensure that at no time the ratio of providers to families served exceeds 1:15. If at any time the ratio exceeds 1:15, Provider shall immediately notify Health Plan so that Health Plan may take appropriate next steps pursuant to Health Plan's policies and procedures.

1.12 **Data Collection and Reporting.** In order to support Provider and Health Plan's joint efforts to serve Members and in service of the OHA's requirements to collect data about the delivery of Wraparound services, Provider agrees to provide reporting to Health Plan that includes the following:

- Wraparound Annual Utilization Report (annually)
- Number of youth served (monthly)
- Ratio of employed or contracted staff to total number of youth served (monthly)

- Number of requests for Wraparound services and number enrolled in Wraparound, including explanations for those not enrolled (monthly)
- Number of youth discharged from Wraparound (monthly)
- Race/Ethnicity and Language of eligible members enrolled in and discharged from Wraparound (monthly)

1.13 Reporting Penalties. Provider agrees to supply the reporting deliverables listed in Section 1.12. Provider agrees to indemnify and hold Health Plan harmless against any and all fines, fees, and/or assessments assessed by the Oregon Health Authority as a result of Provider's failure to timely meet the reporting deliverables identified in this Agreement.

1.14 Encounter Data. Provider agrees to submit claims for all Wraparound services provided by Wraparound staff, as identified in Section 1.4. All Wraparound services (excluding CANS assessments billed using H2000) shall be submitted and include the member's diagnosis or diagnoses, Procedure Code H2021, Community-based Wraparound Services, per 15 minutes, and the number of units per service (e.g., a 45 minute encounter would require claim submission of H2021 for 3 units). These claims are for encounter reporting purposes only and will not be reimbursed, per payment agreement in Attachment A.

1.15 Workforce Training. Provider shall ensure that all staff receive training as required in the Contract such as, but not limited to, Cultural Responsiveness, Implicit Bias, CLAS Standards, Trauma Informed Care, and uses of data to advance health equity to name a few. Provider and provider staff may access trainings offered by the PacificSource Training Program. For all other training, Provider shall have mechanisms in place that enable reporting to Health Plan, at Health Plan's reasonable request, details of training activities, annual training plans, training subjects, content outlines, objectives, target audiences, delivery system, evaluations, training hours, training attendance, and trainer qualifications. At a minimum, Provider shall provide Health Plan with an Annual Training and Education Report so that Health Plan may compile such information into Health Plan's report to the OHA.

2. PAYMENT.

Provider shall be paid for providing the Wraparound Work pursuant to Attachment A of the Agreement.

3. TERM AND TERMINATION.

This Addendum shall be in full force and effect for the Term of the Agreement, unless earlier terminated as provided herein. Either Party may terminate this Addendum, without impacting the Agreement, with the other Party's written consent, which shall not be unreasonably withheld.

4. DATA USE.

The Parties recognize and agree that it may be necessary to share certain data with each other that was not anticipated to give this Addendum its full force and effect. The Parties agree that they will meet and determine the exact data to provide, in accordance with the terms of this Addendum, as it becomes necessary. The additional specifications for that

data may be added as an amendment, at any time, to this Addendum as mutually agreed to by the Parties. The Parties acknowledge that the CCO Contract requires significant reporting to OHA, including documentation establishing compliance with OAR 309-019-0326, and agree to work together to ensure the proper completion and filing of such reports so that Health Plan may fulfill its obligations under the CCO Contract. Provider acknowledges that OHA will post many of the reports on its website. Where redaction of certain information is allowed, the Parties will coordinate on the identification of those redactions, although Health Plan will have the right to make the final redactions based on its sole discretion.

AMENDMENT #5 TO

PacificSource / Marion County, a political subdivision of the State of Oregon

PARTICIPATING PROVIDER SERVICE AGREEMENT

Effective **August 01, 2021,** the PacificSource Participating Provider Service Agreement with Marion County, a political subdivision of the State of Oregon is amended as follows:

I. **Section 2.3 Program-Based Reimbursement** dated effective 1/1/20 shall be replaced with the following **Section 2.3 Program-Based Reimbursement** effective 8/1/2021.

Except for the changes described herein, the Participating Provider Service Agreement remains unchanged.

PACIFICSOURCE COMMUNITY SOLUTIONS

By: _____
(Signature)

Peter McGarry
(Print or type name)

Title: Vice President – Provider Network

Date: _____

Marion County, a political subdivision of the State of Oregon

By: _____
(Signature)

Ryan Matthews
(Print or type name)

Title: Administrator

Date: _____

2.3 Program-Based Reimbursement

Reimbursement for the services and programs defined below will be calculated as a per-member per-month (PMPM) payment of $8.48 based on full CCO (not county-specific) membership eligible for mental health benefits. The PMPM payment will be made prospectively based on the rates listed below with retroactive reconciliation as described below completed by PacificSource based on quarterly Provider reports using PacificSource's reporting template.

Services and Programs	Unit of Measure	$ per Unit	Budgeted Units (not to exceed)	Estimated Annual Payment	Actual Payment PMPM
Local Public Health Authority Services	n/a	n/a			$0.31
Local Mental Health Authority Services (i.e. residential care coordination, civil commitment, system coordination)	n/a	n/a			$0.12
Fidelity Wraparound Program (inclusive of all services, including those subcontracted)	Per member per month	$1,110	n/a	n/a	n/a
Professional Supervision for Licensure	Per trainee	$6,000	20	$120,000	$0.10
Community Support Services (CSS)* Total	n/a	n/a			$7.95
Northwest Human Services Crisis Line	n/a	n/a	n/a	$80,000	n/a
Total Program Support	n/a	n/a			**$8.48**

Allocation of payment for Community Support Services*					
Crisis (including Mobile)					$2.09

Services and Programs	Description, Conditions, and Reporting
Community Support Services (CSS)* Total	Allocation of Program Support payment across CSS will be recalculated during the third quarter of each calendar year based on Provider's prior fiscal year budget and actual financials. Reporting: Actual expenditures, enrollment, performance, and outcomes.
Professional Supervision for Licensure	Description: Trainee is defined as a Mental Health Intern or an individual who has completed required academic degree for practice and are being supervised by a Provider employed or contracted clinician under a board-approved supervisory agreement in a clinical mental health field. Reporting: Quarterly roster of eligible trainees by name with clinical hours accrued quarterly and each trainee's total hours of supervision completed.

Services and Programs	Description, Conditions, and Reporting
	Payment: Average monthly Full Time Equivalent trainees over the quarter will be calculated. Payment will be recouped and/or PMPM payment reduced proportionately for every trainee below Budgeted Units listed above.
Fidelity Wraparound Program	Condition: Fidelity to OHA model Reporting: Monthly enrollment and enrollee encounters. On or before the 5th of the month, Provider shall send an invoice to PacificSource Community Solutions for invoicing purposes. This invoice shall indicate members served in the previous month and include the following data: - Member name - Member date of birth - Member identification number PacificSource shall verify member eligibility and coverage, prorating the monthly rate should the member have not been eligible for services for the entire month. Provider will submit additional data elements as determined by PacificSource in order to verify the services rendered and member eligibility.
Assertive Community Treatment (ACT)	PacificSource and Provider shall collaborate to monitor ACT need, enrollment and capacity in the region in order to make good use of available capacity and not waitlist any eligible clients. PacificSource will add $0.15 PMPM to the Program Support payment to Provider for each additional ten (10) clients served over the 55 original client capacity.
Marion County funding for community programs	Should Marion County decide to discontinue any funding for community programs that are included in this contract or part of CMHP duties, PacificSource Community Solutions will be given 365 days' notice.

The following codes will be encountered at 100% of OHP fee schedule or, when not listed on the OHP fee schedule, PacificSource Community Solutions Default Fee Allowance, but these codes will not be paid because their value is included in the Program payments detailed above:

Crisis	H2011, S9125, S9484, T1015
Training/Skills/Case Management	G0176, G0177, H0036, H0039, H0046, H2014, H2018, H2021, H2022, H2023, H2027, H2032, H2033, T1016
Medical services – within scope of nursing staff	H0034, H2010

Amendment #4

PacificSource Community Solutions

AMENDMENT TO

PacificSource Community Solutions /Marion County, a political subdivision of the State of Oregon

PARTICIPATING PROVIDER SERVICE AGREEMENT

Effective **January 01, 2020,** the PacificSource Participating Provider Service Agreement with Marion County, a political subdivision of the State of Oregon is amended as follows:

I. The following CCO Quality Improvement Metric (QIM) performance metrics shall replace the current metrics in section 6.0 Performance Measures and Reporting.

1. Prenatal & Postpartum Care – Postpartum Care (2020 OHA Aligned Measure #14)	
Weighting	N/A
Performance Monitoring	PacificSource reporting using PacificSource hybrid data: administrative claims and medical chart audit
Final Result	OHA 2020 Reporting Only
Target	While OHA Marion-Polk County CCO 2020 is Reporting Only; Provider Partners are still required to participate[2] and submit data for this measure
Population	Marion-Polk County CCO Members
Denominator	Per OHA (QIM) Current Specifications
Numerator	Per OHA (QIM) Current Specifications
Measure Steward	OHA/NCQA
2. Diabetes HbA1c Poor Control (2020 OHA Aligned Measure #29)	
Weighting	N/A
Performance Monitoring	PacificSource reporting using Marion-Polk CCO clinic electronic health record data
Final Result	OHA 2020 Reporting Only
Target	OHA Marion-Polk County CCO 2020 is Reporting Only; Provider Partners are still required to participate and submit data for this measure[1]
Population	Marion-Polk County CCO Members
Denominator	Per OHA (eCQM) Current Specifications
Numerator	Per OHA (eCQM) Current Specifications
Measure Steward	OHA/CMS

[1]Final 2020 eCQM data submissions must be received by PacificSource from participating clinics no later than 11:59 PM PST on January 20, 2021. All submissions are subject to audit by PacificSource for accuracy. Final data submissions must be sent via previously agreed upon SFTP or via email to the following recipient: ecqmreporting@pacificsource.com

[2]By participating, provider organizations will either submit prenatal/postpartum charts, provided remote EHR access, perform audit internally or allow PacificSource Audit Team to come onsite.

Except for the changes described herein, the Participating Provider Service Agreement remains unchanged.

PACIFICSOURCE COMMUNITY SOLUTIONS

By: _____ (Signature)

Peter McGarry

Title: Vice President – Provider Network

Date: 12-14-2020

Marion County, a political subdivision of the State of Oregon

By: _____ (Signature)

Ryan Matthews (Print or type name)

Title: Administrator

Date: 11/20/20

PACIFICSOURCE – Amendment 4
MARION COUNTY SIGNATURE

Authorized Signature: _____ 11/20/20
Ryan Matthews, Administrator — Date

Authorized Signature: N/A
Cydney Nestor, Division Director — Date

Authorized Signature: N/A
Jeremiah Elliott, Sr. Admin Serv. Mgr. — Date Service Code

Authorized Signature: _____ 12/11/2020
Chief Administrative Officer — Date

Reviewed by Signature: _____ 12/10/20
Marion County Legal Counsel — Date

Reviewed by Signature: _____ 12/9/20
Marion County Contracts & Procurement — Date

Amendment #3

PacificSource Community Solutions

AMENDMENT TO

PacificSource / Marion County, a political subdivision of the State of Oregon

PARTICIPATING PROVIDER SERVICE AGREEMENT

Effective **December 01, 2020,** the PacificSource Participating Provider Service Agreement with Marion County, a political subdivision of the State of Oregon is amended as follows:

I. **Clause 4.1 Term and Renewal.** shall be replaced with the following:

4.1 Term and Renewal. The term of this Agreement shall begin on the Effective Date and shall continue for an initial term of one (1) year. Thereafter, this Agreement shall remain in effect until terminated in accordance with this Section or updated via signed amendment.

Except for the changes described herein, the Participating Provider Service Agreement remains unchanged.

PACIFICSOURCE COMMUNITY SOLUTIONS

By: _____
(Signature)

Peter McGarry

Title: Vice President – Provider Network

Date: 12-14-2020

Marion County, a political subdivision of the State of Oregon

By: _____
(Signature)

Ryan Matthews
(Print or type name)

Title: Administrator

Date: 11/20/20

PACIFICSOURCE – Amendment 3
MARION COUNTY SIGNATURE

Authorized Signature: _____ 11/20/20
Ryan Matthews, Administrator — Date

Authorized Signature: N/A
Cydney Nestor, Division Director — Date

Authorized Signature: N/A
Jeremiah Elliott, Sr. Admin Serv. Mgr. — Date Service Code

Authorized Signature: _____ 12/11/2020
Chief Administrative Officer — Date

Reviewed by Signature: _____ 12/10/20
Marion County Legal Counsel — Date

Reviewed by Signature: _____ 12/9/20
Marion County Contracts & Procurement — Date

PacificSource Community Solutions

AMENDMENT TO

PacificSource / Marion County, a political subdivision of the State of Oregon

PARTICIPATING PROVIDER SERVICE AGREEMENT

Effective **July 01, 2020,** the PacificSource Participating Provider Service Agreement with Marion County, a political subdivision of the State of Oregon is amended as follows:

I. **Section 2.3 Program-Based Reimbursement** dated effective 1/1/20 shall be replaced with the following **Section 2.3 Program-Based Reimbursement** effective 7/1/2020.

Except for the changes described herein, the Participating Provider Service Agreement remains unchanged.

PACIFICSOURCE COMMUNITY SOLUTIONS

By: _____ (Signature)

Peter McGarry

Title: Vice President – Provider Network

Date: 8-6-2020

Marion County, a political subdivision of the State of Oregon

By: _____ (Signature)

Ryan Matthews

Title: Interim Administrator

Date: 7/22/20

PACIFIC SOURCE – Amendment 2
MARION COUNTY SIGNATURE

Authorized Signature: _____ 7/22/20 347407/347409
Jeremiah Elliott, Sr Admin Service Manager — Date — Service Code

Authorized Signature: _____ 7/22/20
Cydney Nestor, Division Director — Date

Authorized Signature: _____ 8/3/20
Chief Administrative Officer — Date

Authorized Signature: _____ 7/30/20
Marion County Legal Counsel — Date

Authorized Signature: _____ 7/27/20
Marion County Contracts & Procurement — Date:

2.3 Program-Based Reimbursement

Reimbursement for the services and programs defined below will be calculated as a per-member per-month (PMPM) payment based on full CCO (not county-specific) membership eligible for mental health benefits. The PMPM payment will be made prospectively based on the rates listed below with retroactive reconciliation as described below completed by PacificSource based on quarterly Provider reports using PacificSource's reporting template.

Services and Programs	Unit of Measure	$ per Unit	Budgeted Units (not to exceed)	Estimated Annual Payment	Actual Payment PMPM
Local Public Health Authority Services	n/a	n/a			$0.31
Local Mental Health Authority Services (i.e. residential care coordination, civil commitment, system coordination)	n/a	n/a			$0.12
Children's Wraparound Care Coordination	Per team (15 youth)	$200,000	10.3	$2,060,000	$1.65
Professional Supervision for Licensure	Per trainee	$6,000	20	$120,000	$0.10
Community Support Services (CSS)* Total	n/a	n/a			$7.95
Total Program Support	n/a	n/a			**$10.13**

Allocation of payment for Community Support Services*					
Crisis (including Mobile)					$2.09

Services and Programs	Description, Conditions, and Reporting
Community Support Services (CSS)* Total	Allocation of Program Support payment across CSS will be recalculated during the third quarter of each calendar year based on Provider's prior fiscal year budget and actual financials. Reporting: Actual expenditures, enrollment, performance, and outcomes.
Professional Supervision for Licensure	Description: Trainee is defined as a Mental Health Intern or an individual who has completed required academic degree for practice and are being supervised by a Provider employed or contracted clinician under a board-approved supervisory agreement in a clinical mental health field. Reporting: Quarterly roster of eligible trainees by name with clinical hours accrued quarterly and each trainee's total hours of supervision completed. Payment: Average monthly Full Time Equivalent trainees over the quarter will be calculated. Payment will be recouped and/or PMPM payment reduced proportionately for every trainee below Budgeted Units listed above.

Services and Programs	Description, Conditions, and Reporting
Children's Wraparound Care Coordination	Condition: Fidelity to OHA model Reporting: Monthly enrollment and enrollee encounters. Total capacity 170 youth. Estimate 90% of enrolled clients (capacity 155) will be CCO members, averaged over course of the calendar year. Future years' payments will be adjusted if Provider reporting indicates actual enrollment that deviates significantly and persistently from this estimate.
Assertive Community Treatment (ACT)	PacificSource and Provider shall collaborate to monitor ACT need, enrollment and capacity in the region in order to make good use of available capacity and not waitlist any eligible clients. PacificSource will add $0.15 PMPM to the Program Support payment to Provider for each additional ten (10) clients served over the 55 original client capacity.

The following codes will be encountered at 100% of OHP fee schedule or, when not listed on the OHP fee schedule, PacificSource Community Solutions Default Fee Allowance, but these codes will not be paid because their value is included in the Program payments detailed above:

Crisis	H2011, S9125, S9484, T1015
Training/Skills/Case Management	G0176, G0177, H0036, H0039, H0046, H2014, H2018, H2021, H2022, H2023, H2027, H2032, H2033, T1016
Medical services – within scope of nursing staff	H0034, H2010

PacificSource
Community Solutions

PARTICIPATING PROVIDER AGREEMENT

This Participating Provider Agreement is made and entered into by and between **PacificSource Community Solutions**, an Oregon non-profit corporation ("PacificSource") and **Marion County, a political subdivision of the State of Oregon** ("Provider"). The effective date of this Agreement is **January 1, 2020** (the "Effective Date").

WHEREAS, PacificSource is, or is intending to be a company contracted with the State of Oregon, acting by and through the Oregon Health Authority ("OHA"), Health Systems Division ("HSD"), to implement and administer services under the Oregon Health Plan in certain counties in Oregon;

WHEREAS, Provider is either a) a provider who is HSD approved and duly licensed to practice his or her specialty in the State of Oregon or b) a provider entity, which provides services under this Agreement through its partners, independent contractor(s), and/or employee(s), and/or Provider is a facility duly licensed by the state of Oregon for the care of patients and meets the requirements of the state of Oregon laws for staffing and services to provide inpatient, outpatient, and/or emergency services (a "Licensed Facility");

WHEREAS, the parties mutually desire to enter into this Agreement to provide Covered Services to PacificSource Members under a Coordinated Care Organization Contract ("CCO Contract") with the OHA; and

WHEREAS, the parties intend that should any reasonable ambiguity arise in the interpretation of a provision of this Agreement, the provision shall be construed to be consistent with the legal requirements of the State of Oregon, the CCO Contract, or other legal requirements, as applicable.

NOW, THEREFORE, in consideration of the mutual covenants and agreements, the parties hereby agree as follows:

1.0 DEFINITIONS

1.1 Agreement. "Agreement" means this Participating Provider Agreement, including any and all recitals, amendments, exhibits, attachments, schedules, and addenda, now or hereafter entered into, between Provider and PacificSource.

1.2 Behavioral Health. "Behavioral Health" means mental health, mental illness, addiction disorders, and substance use disorders.

1.3 Clean Claim. "Clean Claim," means a claim received by PacificSource for payment of Covered Services rendered to a Member which can be processed without obtaining additional information from Provider or from a third party and has been received within

the time limitations set forth herein. A Clean Claim does not include a claim from a Provider who is under investigation for fraud or abuse or a claim under review for Medical Necessity. A Clean Claim is a "clean claim" as defined in 42 CFR 447.45(b).

1.4 Coordinated Care Organization. "Coordinated Care Organization" ("CCO") means a corporation, governmental agency, public corporation, or other legal entity that is certified as meeting the criteria adopted by the Authority under ORS 414.625 to be accountable for care management and to provide integrated and coordinated health care for each of the organization's members.

1.5 Copayments. "Copayments" are defined as a fixed amount a Member is responsible to pay for a Covered Service, as may be provided in the Member's Health Benefit Plan.

1.6 Covered Services. "Covered Services" are defined as Medically Appropriate health services that are funded by the legislature of the State of Oregon and described in ORS 414.706 to 414.770; OAR 410-120-1210, Medical Assistance Benefit Packages and Delivery System; OAR 410-141-0120, Managed Care 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; except as excluded or limited under OAR 410-141-0500, Excluded Services and Limitations for Oregon Health Plan clients and/or Division members; all as such statutes and rules exist today or as amended in the future.

1.7 Covering Practitioner. "Covering Practitioner" means a PacificSource Provider or, with prior PacificSource approval, a practitioner who is not a PacificSource Provider, who provides Covered Services to Members for or on behalf of Provider during an emergency or temporary unavailability such as a vacation or illness.

1.8 Emergency Services. "Emergency Services" are defined as Covered Services from a qualified provider necessary to evaluate or stabilize an emergency medical condition, including inpatient and outpatient treatment that may be necessary to assure within reasonable medical probability that the Member's condition is likely to materially deteriorate from or during a Member's discharge from a facility or transfer to another facility. OAR 410-120-0000(91).

1.9 Emergency Medical Condition. "Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part. An Emergency Medical Condition is determined based on the presenting symptoms (not the final diagnosis) as perceived by a prudent layperson (rather than a health care professional) and includes cases in which the absence of immediate medical attention would not in fact have had the adverse results described in the previous sentence. OAR 410-120-0000(89). The decision of whether a condition requires Emergency Services rests with PacificSource and is subject to its procedures for post-treatment utilization review consistent with the standards under federal or Oregon law, as applicable.

1.10 Health Benefit Plan. "Health Benefit Plan" means the Benefit Package, as that term is defined in OAR 410-120-0000(34), of Covered Services under the Oregon Health Plan for which the Member is eligible.

1.11 Medically Appropriate. "Medically Appropriate" means health services, items, or medical supplies that are:

(a) Recommended by a licensed health provider practicing within the scope of their license;

(b) Safe, effective, and appropriate for the patient based on standards of good health practice and generally recognized by the relevant scientific or professional community based on the best available evidence;

(c) Not solely for the convenience or preference of a Member or a provider for the service item or medical supply; and

(d) The most cost effective of the alternative levels or types of health services, items, or medical supplies that are Covered Services that can be safely and effectively provided to a Member in PacificSource's judgment. OAR 410-120-0000(145).

1.12 Member. "Member" means an individual who is found eligible by the Oregon Health Authority, including such divisions, programs, and offices as may be established therein, to receive services under the Oregon Health Plan, is enrolled with PacificSource and eligible to receive Covered Services, and to whom Provider is required to provide Covered Services pursuant to this Agreement.

1.13 Non-Covered Services. "Non-Covered Services" are defined as all health care services that are not Covered Services under the Member's Health Benefit Plan.

1.14 Oregon Health Authority. "Oregon Health Authority" is an Oregon state government agency.

1.15 Oregon Health Plan. "Oregon Health Plan" ("OHP") means the Oregon Medicaid Demonstration Project, as established by chapter 815, Oregon Laws 1993, and later amended.

1.16 Other Payor. "Other Payor" shall mean other payors for healthcare services, including but not limited to PacificSource subsidiaries, trusts, and governmental entities or authorized contracting entities or divisions, with whom PacificSource has entered into a contract.

1.17 PacificSource Provider Manual. "PacificSource Provider Manual" means a document developed and maintained by PacificSource, which provides instruction regarding standard policy and procedural requirements of PacificSource and is provided online on PacificSource's website in the provider section.

1.18 PacificSource Providers. "PacificSource Providers" means institutional or non-institutional health care entities or individuals that are under contract, directly or indirectly, with PacificSource to provide Covered Services to Members.

1.20 Substance Use Disorders. "Substance Use Disorders" means disorders related to the taking of a drug of abuse including alcohol, to the side effects of a medication, or to a toxin exposure. The disorders include substance use disorders, such as substance dependence and substance abuse, and substance-induced disorders, such as substance intoxication, withdrawal, delirium, dementia, and substance-induced psychotic or mood disorder, as defined in DSM-V criteria.

1.21 Urgent Care Services. "Urgent Care Services" are defined as Covered Services that are Medically Appropriate and immediately required to prevent a serious deterioration of a Member's health that results from an unforeseen illness or an injury. OAR 410-120-0000(250). Services that can be foreseen by the individual are not considered Urgent Care Services.

2.0 PROVIDER RESPONSIBILITIES.

2.1 Provider Services; Requirements. Provider shall:

(a) Provide or arrange for the provision of Covered Services detailed in Attachments B-1 and B-2, to Members and beneficiaries of any Other Payor on an as-needed basis within the scope of Provider's licensing, training, experience, and qualifications and consistent with accepted standards of medical practice and the terms and conditions of this Agreement and any other applicable contract or similar arrangement. Provide Covered Services to the members or beneficiaries of any Other Payor, pursuant to each applicable agreement between PacificSource and any Other Payor, and pursuant to and in accordance with the provisions of this Agreement.

(b) To the extent Provider is a Licensed Facility, provide those inpatient, outpatient, and Emergency Medical Services detailed in Attachments B1 and B2 for which it is licensed and which are Covered Services on an as-needed basis within the scope of Facility's licensing, training, experience, and qualifications, and consistent with accepted standards of medical practice and the terms and conditions of this Agreement. Facility shall not be required to provide any Covered Services to Members that Facility does not customarily and routinely offer to other patients. Facility has the right to refuse to treat disruptive, disorderly, or dangerous Members according to the same standards and policies applied to its other patients.

(c) Devote sufficient time, attention, and energy necessary for the competent and effective performance of Provider's duties under this Agreement to Members who select Provider or are otherwise designated, assigned, or referred to Provider by PacificSource.

(d) Meet standards for timely access to care and services as specified in the CCO Contract and, when not specified in the CCO Contract, Oregon Administrative Rules, including 410-141-3220 and 410-141-3160.

(e) Meet National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (The National CLAS Standards) (including mandatory

training) established by the U.S. Department of Health and Human Services by providing effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

(f) Ensure that its facilities under contract, if any, can meet cultural responsiveness and linguistic appropriateness standards in addressing the needs of adolescents, parents with dependent children, pregnant women, IV drug users, and Members with medication assisted therapy needs.

(g) Communicate and coordinate care with the Patient-Centered Primary Care Home utilized by Members, if any, in a timely manner using electronic health information technology to the maximum extent feasible.

(h) Work with PacificSource to further access to and coordination with social and support services, including culturally specific community-based organizations, community based mental health services, DHS Medicaid-funded long term care services, and mental health crisis management services.

(i) Not seek payment from either PacificSource or Member for costs resulting from a Provider-Preventable Condition, as that term is defined in 42 CFR 447.26(b). Provider shall identify Provider-Preventable Conditions related to a Member to PacificSource and comply with all reporting requirements that OHA or PacificSource may require.

(j) Collaborate with PacificSource, the CCO's Community Advisory Council, and other stakeholders in completing a Community Health Assessment and Community Health Improvement Plan and in carrying out activities to implement the Community Health Improvement Plan.

(k) Participate in data submission activities pertinent to CCO quality improvement or incentive programs, complete patient experience surveys and share results with entities participating in the CCO, and participate in sharing of quality and performance data with entities participating in the CCO.

2.2 Personnel. Provider shall devote sufficient time, attention, and energy necessary for the competent and effective performance of Provider's duties under this Agreement to Members who select Provider or are otherwise designated, assigned, or referred to Provider by PacificSource. Provider will provide sufficient licensed and experienced personnel, will supervise their professional medical services, and will provide health care services at all agreed upon times and days to meet the needs of Members. All non-physician personnel reasonably required for the proper operation of Provider, including but not limited to licensed and non-licensed health care personnel and administrative personnel, shall be employed by or under contract with Provider. Provider shall be responsible for all compensation, benefits, and costs in connection with such personnel and be responsible in all respects resulting from the employment of or contracting with such personnel. Decisions with respect to hiring control, direction, and termination of such personnel shall be the sole responsibility of Provider.

2.3 Non-Discrimination. Providers shall not discriminate between Members and non-Members as it relates to benefits and services to which they are both entitled and shall ensure that Provider offers hours of operation to Members that are no less than those offered t**o non-Members as provided in OAR 410-141-3220.** Provider shall not discriminate in the treatment of Members based upon physical or medical disability, medical condition, race, color, national origin, ancestry, religion, sex, marital status, veteran status, sexual orientation, or age, to the extent prohibited by applicable federal, state, and local laws, regulations, and ordinances, and Provider shall provide services to Members in the same manner, in accordance with the same standards, and within the same availability as to non-Members. Provider's decision to contract with PacificSource for the provision of certain services or to not contract to provide certain services shall not constitute discrimination hereunder.

2.4 Pre-authorization Program. Except for Emergency Medical Services, Provider will cooperate fully with PacificSource's pre-authorization program. PacificSource will notify Provider reasonably in advance when Covered Services are added to or removed from the pre-authorization program. Prior approval of all procedures or services listed on the pre-authorization grid is required, and any claims submitted for such procedures without prior approval will be denied. The pre-authorization grid is provided on-line on PacificSource's website in the provider section.

2.5 Referrals. Except (a) in the event of an emergency, (b) where otherwise approved or directed in advance by PacificSource, or (c) where a Member's medical needs otherwise require, Providers shall refer Members only to PacificSource Providers and shall refer Members for hospital services only to PacificSource Provider hospitals. Provider shall comply with PacificSource's referral authorization procedures as set forth in the PacificSource Provider Manual.

2.6 Emergency Coverage. Provider shall be responsible for responding to or making arrangements for emergent needs of Members with respect to Covered Services twenty-four (24) hours per day, seven (7) days per week, including holidays. In the event that Provider is unable to provide required Covered Services, Provider shall arrange for a Covering Practitioner.

2.7 Billing Procedure

2.7.1 Covered Services; Hold Harmless. For all Covered Services provided by Provider under this Agreement, Providers shall bill and submit encounter data to PacificSource in accordance with OAR 410-141-0420 and the PacificSource Provider Manual of this Agreement. Provider shall agree that never, under any circumstances, including, but not limited to, non-payment by PacificSource, insolvency of PacificSource, or the breach, expiration or termination of this Agreement, will Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against OHA, Members, or persons acting on Members' behalf, for Covered Services and shall regard payment by PacificSource as payment in full for all benefits covered by this Agreement, with the exception of Copayments specifically authorized in a Member's Health Benefit Plan. The obligations of this Section shall survive the

termination of this Agreement regardless of the cause giving rise to termination. In addition, Provider shall not bill in any amount greater than would be owed if Provider provided the services directly, consistent with 42 CFR 438.106 and 42 CFR 438.230.

2.7.2 Non-Covered Services. For all Non-Covered Services provided to any Member, Provider may bill Member directly for Non-Covered Services if, prior to providing Non-Covered Services, Provider shall have advised Member of non-coverage and shall obtain Member's acknowledgment and acceptance of individual financial responsibility ("Agreement to Pay"). Such Agreement to Pay shall be obtained in writing in a form published by OHA in accordance with OAR 410-141-0420.

2.7.3 Actions to Collect Amounts Owed. Provider shall not maintain any action at law or equity against OHA or any Member to collect any sum owed to Provider by PacificSource for Covered Services rendered pursuant to this Agreement. Provider shall not pursue legal or other remedy against PacificSource for nonpayment or underpayment to Provider for Covered Services provided to a Member unless and to the extent that PacificSource has failed to pay Provider for such Covered Services as required by this Agreement and Provider has exhausted any appeal rights or PacificSource becomes insolvent.

2.7.4 Claims Policies and Procedures. Provider agrees to comply with claims policies and procedures as identified in the PacificSource Provider Manual, which shall be consistent with industry standards for billing and coding practices. Provider agrees that claims must be submitted within four (4) months of the provision of services, except under the following circumstances: (a) billing is delayed due to eligibility issues; (b) pregnancy of the Member; (c) Medicare is the primary payer; (d) cases involving third party resources; (e) Covered Services provided by non-participating providers that are enrolled with OHA; or (f) other circumstances in which there are reasonable grounds for delay, as determined by PacificSource. Claims submitted after the applicable time period as specified in this Section will be denied, and Provider shall not seek reimbursement for such denied claims from Members. Provider agrees to abide by OHA's Provider-Preventable Conditions rules and requirements regarding non-payment of claims by PacificSource should preventable conditions occur.

2.7.5 Bill Review. Provider agrees to cooperate with any requests by PacificSource, or its agent, to review any bills submitted by Provider to determine whether a bill submitted for services rendered to a Member is a Covered Service under the Member's Health Benefit Plan, subject to this Agreement, properly billed to the services provided (as reflected in the medical record), and that payments made to the Provider were accurate, in accordance with the terms and conditions set forth herein.

2.8 Compliance with PacificSource Policies and Procedures. Provider shall participate in, cooperate with, and comply with all applicable PacificSource requirements, policies, and procedures, including, but not limited to, those set forth in the PacificSource Provider Manual which relate to services provided by Provider and those relating to Member

grievances; credentialing; utilization review; quality assurance; information and document requests; requesting hospital admission or specialty services; medical records sharing for specialty treatments, at the time of hospital admission or discharge, and for after-hospital follow-up appointments; and medical management program(s). PacificSource agrees to make any such requirements, policies, and procedures available to Provider upon request within 72 business hours. Provider acknowledges that such PacificSource requirements and procedures may be amended from time to time. Any amendment will not materially alter the obligations of the Provider under this contract without the Provider's written consent. Provider acknowledges receiving, or having access to PacificSource's policies regarding Grievance, Notice of Adverse Benefit Determination, Appeals, and Contested Case Hearings, and access to the PacificSource Provider Manual.

2.9 **Cooperation with UM and Quality Improvement Activities;** PacificSource Committee and Corrective Action Plans. Provider agrees to cooperate with utilization management and quality management procedures specified by the OHA, including OHPB Policy #31, or enacted by PacificSource and communicated to Provider by PacificSource. If PacificSource's quality review activities involve post-payment record reviews or audits, such activities shall be limited to Member records and shall be conducted at PacificSource's expense, not including the cost of accessing and/or copying records. Provider shall provide at no cost, up to 10 records per Provider per audit, after which the parties shall split the reasonable costs. Provider agrees to PacificSource's audit schedule, and PacificSource shall not unreasonably interfere with Provider's business operations for the purpose of such audit. Provider shall cooperate with PacificSource, or its designee, in the performance of quality improvement and related activities. Failure to comply with PacificSource utilization review requirements or respond to post-payment record reviews or audits may result in a PacificSource request for a return of monies paid to Provider. If such amounts are not refunded or a reasonable accommodation for repayment cannot be reached between PacificSource and Provider, PacificSource may setoff such monies against amounts owed to Provider. The setoff right provided above may only be exercised upon prior written notice to Provider. For any return requests or setoff notices, Provider shall be given an opportunity to be heard by PacificSource.

2.9.1 Quality Improvement Programs. Provider will participate and/or promote applicable quality improvement programs, which are designed to improve the quality of care, quality of service, and the Member's experience. Such programs may include initiatives designed or required by regulatory or accreditation entities and may include without limitation data sharing via access to Provider's electronic health records, collection and evaluation of health data, providing access to supplemental data for collection of health data, providing applicable contact information to facilitate medical record chart chases, responding to Member complaints and quality of care concerns, responding to program evaluations and satisfaction surveys, and allowing PacificSource to use Provider performance data for quality improvement activities. Provider will also participate in CCO incentive measures which include data sharing via access to Provider electronic health records, participation in PacificSource incentive and improvement programs, and other measures or metrics as applicable.

2.9.2 Oversight. PacificSource shall oversee and is accountable to OHA for any functions or responsibilities delegated to Provider. This shall include, without limitation, PacificSource conducting a formal review of compliance with delegated responsibilities and Provider performance, deficiencies or areas for improvement, in accordance with 42 CFR 438.230(a)(1). Upon identification of deficiencies or areas for improvement, PacificSource shall cause Provider to take Corrective Action.

2.9.3 Corrective Action Plans. PacificSource may determine that Provider's performance of obligations, duties, and responsibilities under the terms of this Agreement is deficient within reasonable standards and expectations. In reaching that conclusion, PacificSource may, but is not required to, consider third-party audit or other formal review results, peer review results, quality measures, written or oral feedback from Members or patients, and any other issues which may be identified by PacificSource. If PacificSource determines Provider's performance is deficient for any reason, but that such deficiency does not constitute a Material Breach of the terms of this Agreement, PacificSource may declare the need for corrective action and issue to Provider or request from Provider a corrective action plan ("CAP") subject to internal review and approval. Provider shall have thirty (30) days to resolve the CAP to PacificSource's satisfaction. Failure to resolve the CAP shall constitute a Material Breach by Provider, and PacificSource may terminate this Agreement immediately or take other action including financial penalties, imposition of liquidated damages, or sanctions.

2.10 Provider Practice. Subject to the terms and conditions of this Agreement, Provider shall be entitled to perform all usual and customary procedures relative to their practice. This Agreement does not, and shall not be interpreted as, prohibiting or otherwise restricting Provider who is acting within the lawful scope of practice from advising or advocating on behalf of Members who are patients of such Provider, for the following:

(a) Members' health status, medical care, or treatment options including any alternative treatment that may be self-administered, that is Medically Appropriate even if such care or treatment is not covered under this Agreement or is subject to copayment;

(b) Any information Members need in order to decide among relevant treatment options;

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

(d) Members' right to participate in decisions regarding their health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

2.11 Professional Representations. Throughout the term of this Agreement, Provider represents and warrants that it shall comply with all of the following regards any licensed practitioners or Provider Entity covered under this Agreement:

(a) Maintain an unrestricted current license to practice his or her specialty under the State jurisdiction in which Covered Services are provided and have in effect at all times all licenses required by law for the practice of such provider's profession;

(b) Maintain credentialing according to NCQA credentialing standards either by PacificSource or PacificSource's agent;

(c) Secure and maintain, at Provider's expense, throughout the term of this Agreement, professional liability insurance in a minimum amount not less than as specified in the PacificSource Provider Manual or as required by state law or OHA;

(d) Obtain and maintain staff privileges at the hospital primarily used by PacificSource Providers, assuming privileges are available and appropriate to that class of provider;

(e) Agree that this Agreement has been executed by its duly authorized representative and that executing this Agreement and performing its obligations hereunder shall not cause Provider to violate any term or covenant of any other agreement or arrangement now existing or hereinafter executed; and

(f) Notify PacificSource promptly of any (i) modification, restriction, suspension, or revocation of any provider's authorization to prescribe or to administer controlled substances; (ii) imposition of sanctions against Provider under Medicaid, Medicare, or any other governmental program; or (iii) other professional disciplinary action or criminal or professional liability action of any kind against any provider, which is either initiated, in progress, or completed as of the Effective Date of this Agreement and at all times during the term of this Agreement

2.12 Facility Representations. If a Licensed Facility then throughout the term of this Agreement, Provider represents and warrants that Provider shall comply with all of the following regards all Licensed Facilities covered under this Agreement:

(a) Maintain all appropriate license(s) and certification(s) mandated by governmental regulatory agencies;

(b) Maintain accreditation by the Joint Commission on Accreditation of Healthcare Organizations ("Joint Commission") or another applicable accrediting agency recognized by PacificSource;

(c) Maintain compliance with all applicable federal and state laws and regulations related to this Agreement and the services to be provided hereunder, including, without limitation, statutes and regulations related to fraud, abuse, discrimination, disabilities, confidentiality, false claims, and prohibition of kickbacks;

(d) Establish and maintain an ongoing quality assurance/assessment program which includes, but is not limited to, appropriate credentialing of employees and subcontractors and shall supply to PacificSource the relevant documentation, including, but not limited to, internal quality assurance/assessment protocols,

state licenses and certifications, federal agency certifications, and/or registrations upon request;

(e) Ensure that all ancillary health care personnel employed by, associated or contracted with Facility who treat Members are and will remain throughout the term of this Agreement appropriately licensed and/or certified as required by state law and supervised, and qualified by education, training and experience to perform their professional duties; and will act within the scope of their licensure or certification, as the case may be;

(f) Maintain credentialing, privileging, and re-appointment procedures in accordance with its medical staffs by-laws, regulations, and policies, if any; meet the querying and reporting requirements of the National Practitioner Data Bank and Healthcare Integrity and Protection Data Bank ("HIPDB"); and fulfill all applicable state and Federal standards;

(g) Warrant that this Agreement has been executed by its duly authorized representative and that executing this Agreement and performing its obligations hereunder shall not cause Provider to violate any term or covenant of any other agreement or arrangement now existing or hereinafter executed; and

(h) Notify PacificSource promptly of any (i) modification, restriction, suspension, or revocation of Provider's license(s) and/or certification(s); (ii) imposition of sanctions against Provider under the Medicaid program, Medicare program, or any other governmental program; or (iii) other disciplinary action, or criminal or professional liability action of any kind against Provider, which is either initiated, in progress, or completed as of the Effective Date of this Agreement and at all times during the term of this Agreement.

2.13 Credentialing. Provider and practitioners covered under this Agreement agree to comply with credentialing requirements of PacificSource as outlined in the PacificSource Provider Manual and prior to rendering of Covered Services to Members. Provider warrants that it and any practitioner affiliated with Provider meets PacificSource's credentialing standards and that Provider has all licenses, permits, and/or governmental or board authorizations or approvals necessary to provide Covered Services in accordance with the applicable requirements in the state(s) in which Provider conducts business. Provider will provide immediate written notice to PacificSource of any changes in the licenses, permits, and/or governmental or board authorizations or approvals referenced above.

2.14 Provider Information. Provider shall notify PacificSource of any change in Provider information, including but not limited to, address, phone number, tax identification number, open and closed practice status, board certification and hospital privileges in advance of said change. Provider hereby authorizes any and all hospitals that Provider maintains staff privileges at to notify PacificSource promptly following the initiation of any disciplinary or other action of any kind that could result in any suspension, termination, or restriction in any material way, which would affect the ability of Provider to provide Covered Services to Members.

2.15 Coordination of Benefits. Provider agrees to (a) cooperate in providing for effective implementation of the provisions of all Health Benefit Plans and PacificSource policies

relating to coordination of benefits and (b) comply with coordination of benefits policies described in the PacificSource Provider Manual. Provider shall inform PacificSource and OHA if Provider learns that a Member has insurance or health care benefits available from other sources or if a Member's condition is the result of other party liability. Provider will cooperate with PacificSource in pursuing claims against such other payors. In the event of illness or injury for which a third party has accepted financial responsibility or has been judged to be liable, the amount available for collection by Provider from the third party shall be applied to charges for medical care of the Member prior to the resources of PacificSource.

If the third party has reimbursed Provider, or if a Member reimbursed Provider after receiving payment from the third party, then Provider must reimburse Medicare up to the full amount Provider received, if the Member has Medicare and if Medicare is unable to recover its payment from the remainder of the third party payment. If the third party is not liable for the illness or injury of a Member or if recovery from the third party is less than PacificSource's obligation to the Member in the absence of payment by a third party, Provider shall comply with PacificSource's rules governing the provision of Covered Services and the terms of this Agreement in order for PacificSource to accept financial responsibility. Notwithstanding the foregoing, Provider may not refuse to provide Covered Services to a Member because of a potential third party liability, but shall provide Covered Services and cooperate with PacificSource for possible recoupment of funds.

2.16 PacificSource Provider Directory. Provider hereby authorizes PacificSource to list Provider's name, specialty, address, and telephone number in PacificSource's Provider Directory, whether on-line or in print, and in any PacificSource materials to help promote PacificSource or Health Benefit Plans to Members.

2.17 Provider Entities. If Provider is a Provider Entity, Provider shall provide services under this Agreement solely through its individual practitioner shareholders, partners, independent contractors, and/or employees and must ensure that all such shareholders, partners, independent contractors, and/or employees comply with the terms of this Agreement.

2.18 Confidentiality. During and after the term of this Agreement, Provider shall, subject to ORS Chapter 192, keep confidential any financial, operating, proprietary, or business information relating to PacificSource that is not otherwise public or reasonably identified as confidential, including but not limited to, the terms of this Agreement. The obligations of this Section shall survive the termination of this Agreement.

2.19 Non-Disparagement. Provider shall not directly or indirectly engage in Disparagement, as defined below, of PacificSource to any Member without PacificSource's prior written consent. For the purposes of this Section, "Disparagement" shall mean any oral or written statement that is slanderous, defamatory, or intentionally inaccurate, regarding PacificSource that may be reasonably interpreted to be intended to persuade any Member or employer of such Member to disenroll from a Health Benefit Plan or to encourage any Member or employer of such Member to receive health care from Provider other than pursuant to this Agreement. Nothing in this section is intended to interfere with an Provider's ability to communicate with a Member about the Member's

medical condition, proposed treatment, or treatment alternatives whether covered by Health Benefit Plan or not and is consistent with state or federal laws. In addition to any other remedy available at law or in equity, Provider's breach of this Section shall be grounds for termination, pursuant to Section 4.5 (Termination with Cause upon Notice) of this Agreement, from participation in PacificSource's panel of PacificSource Providers and from participation in providing Covered Services to Members in accordance with the terms and conditions of this Agreement.

2.20 Eligibility Verification. Providers will use best efforts to verify the enrollment and assignment of a Member prior to the provision of Covered Services and acknowledge that failure to verify eligibility may result in denial of claims for said Covered Services. PacificSource will use best efforts to provide such enrollment verification information and PacificSource acknowledges that its eligibility verification policies will be consistent with state and/or federal legal requirements.

2.21 Pricing and Quality Transparency. To the extent required by Oregon law, Provider shall promptly provide pricing and quality information to PacificSource as and when requested for the purpose of providing cost estimates to Members.

2.22 Emergency Room Referrals. Providers shall (a) not refer or direct Members to hospital emergency rooms for non-Emergency Medical Conditions and (b) educate and instruct Members in the proper utilization of Provider's office in lieu of the hospital emergency room.

2.23 Subrogation. As required by PacificSource's contract with OHA, Provider agrees to subrogate to OHA any and all claims Provider has or may have against manufacturers, wholesale or retail suppliers, sales representatives, testing laboratories, or other providers in the design, manufacture, marketing, pricing, or quality of drugs, pharmaceuticals, medical supplies, medical devices, DMEPOS, or other products

2.24 Electronic Medical Record Access. Provider agrees to allow PacificSource, upon request, access to its electronic medical record system for the retrieval and review of Member medical records. Such access will be granted on a continuous basis for the duration of this Agreement and PacificSource will agree to reasonable restrictions and rules related to such access.

2.25 Representations and Warranties. Provider represents and warrants that (a) it has the power and authority to enter into and perform this Agreement, (b) this Agreement, when executed and delivered, shall be a valid and binding obligation of Provider enforceable in accordance with its terms, (c) Provider has the skill and knowledge possessed by well-informed members of its industry, trade or profession and Provider will apply that skill and knowledge with care and diligence to perform the services contemplated herein in a professional manner and in accordance with standards prevalent in Provider's industry, trade or profession, and (d) Provider shall, at all times during the term of this Agreement, be qualified, professionally competent, and duly licensed to perform the services contemplated herein.

3.0 PACIFICSOURCE RESPONSIBILITIES

3.1 **Payment.** Provider shall be compensated for Covered Services provided to Members in accordance with Attachments A-1 and A-2. Unless a claim is disputed, PacificSource shall approve for payment Provider's complete, accurate, and timely submitted Clean Claims for Covered Services rendered to a Member, in accordance with PacificSource policies or applicable laws or regulations. The timing and calculation of payment(s) to Provider for Covered Services shall be according to PacificSource's payment methodology as set forth in this Agreement and Attachment(s).

3.2 **Refunds.** PacificSource may initiate refunds from Providers for up to one (1) year from the date of payment. Refund statements are generated on a monthly basis, and PacificSource will setoff consistent with Section 2.9 (Cooperation with UM Quality Improvement Activities; PacificSource Committee and Corrective Action Plans). In the event that HSD retroactively disenrolls a Member, PacificSource reserves the right to initiate provider refunds for any applicable time period, which may be longer than one (1) year from the date of payment.

3.3 **Member Eligibility.** PacificSource shall establish a method for Provider to identify whether a person requesting services is enrolled with PacificSource and eligible to receive Covered Services paid for by PacificSource.

3.4 **Subcontracts.** PacificSource may subcontract any or all of the services PacificSource agrees to provide under this Agreement. No subcontract shall terminate or limit PacificSource's legal responsibility for the timely and effective performance of its duties and responsibilities under this Agreement.

3.5 **Marketing.** PacificSource may, upon approval from Provider, advertise the participation of Provider with PacificSource in print, voice, and video advertising media. PacificSource may list the name, address, telephone number, and other identifying information of Provider in PacificSource's publications furnished to Providers and Members and may identify Provider as a PacificSource Provider in advertising and marketing materials, in accordance with OHA guidelines. Such approval will be determined by Provider on a case by case basis.

3.6 **Choice of Health Care Provider.** PacificSource will allow Member to choose his or her health care provider to the extent possible and appropriate.

4.0 EFFECTIVE DATE; TERM AND TERMINATION.

4.1 **Term and Renewal.** The term of this Agreement shall begin on the Effective Date and shall continue for an initial term of one (1) year. Thereafter, this Agreement shall automatically renew for additional one (1) year periods until terminated in accordance with this Section.

4.2 **Termination without Cause.** Either party may terminate this Agreement at any time upon at least one hundred eighty (180) days prior written notice to the other party.

4.3 Immediate Termination. PacificSource shall have the right to terminate this Agreement immediately by written notice to Provider upon the occurrence of any of the following events:

(a) Provider's license to provide medical services in the state in which services were rendered, as applicable, or authorization to administer controlled substances is terminated, suspended, or restricted in any material way, which would affect the ability of Provider to furnish Covered Services to Members pursuant to the terms of this Agreement;

(b) Provider's medical staff privileges at any licensed general acute care hospital is suspended, terminated, or restricted in any material way, which would affect Provider's ability to provide Covered Services to Members;

(c) Provider is suspended from participation in Medicaid or Medicare programs or not enrolled as a Medicaid Provider with the State of Oregon;

(d) Provider's loss of professional liability coverage as required by this Agreement;

(e) Provider fails to comply with the notification requirements set forth in this Agreement;

(f) PacificSource makes a reasonable and good faith determination that such termination is necessary to protect the health or welfare of Members; or

(g) If Provider is a Provider Entity, Provider (i) ceases to be a professional corporation, medical group partnership, or other health care provider organization in good standing under the laws of the state in which Services were rendered, as applicable, or (ii) there is a change in the majority ownership or control of Provider; or (iii) Provider violates the drug-free workplace provisions in this Agreement.

To protect the interests of Members, Provider will provide immediate notice to PacificSource of any of the aforesaid events. PacificSource shall provide Provider an opportunity to respond to PacificSource's termination decision if the basis for PacificSource's termination decision is based upon mistaken or otherwise erroneous information, and shall otherwise follow any legal requirements that apply.

4.4 Immediate Termination of Licensed Facility. For any Licensed Facilities covered under this Agreement, PacificSource shall have the right to terminate this Agreement immediately by written notice to Provider upon the occurrence of any of the following events:

(a) Withdrawal, expiration, or non-renewal of any Federal, state, or local license, certificate, approval or authorization of Provider;

(b) Bankruptcy or receivership of Provider, or an assignment by Provider for the benefit of creditors;

(c) Loss or material limitation of Provider's insurance;

(d) Debarment or suspension of Provider from participation in any governmental sponsored program, including, but not limited to Medicare;

(e) Failure to comply with the notification requirements set forth in this Agreement, including those in Section 2.11 and 2.12;

(f) Revocation or suspension of Provider's accreditation as required in this Agreement;

(g) The listing of Provider in the HIPDB; or

(h) Change of control of Provider to an entity not acceptable to PacificSource, or there is a change in the majority ownership or control of Provider.

To protect the interests of Members, Provider will provide immediate notice to PacificSource of any of the aforesaid events. PacificSource shall provide Provider an opportunity to respond to PacificSource's termination decision if the basis for PacificSource's termination decision is based upon mistaken or otherwise erroneous information, and shall otherwise follow any legal requirements that apply.

4.5 Termination with Cause upon Notice. PacificSource may terminate a Provider for cause, including, without limitation, quality of care, fraud, waste or abuse concerns, from participation in PacificSource's panel of PacificSource Providers and in the provision of Covered Services to Members pursuant to the terms and conditions of this Agreement. For cause shall not include a Provider advocating a decision, policy, or practice solely for reason of such advocacy. In the event of a termination for cause, Provider is entitled to those rights of appeal as described in PacificSource's Appeal Process for Terminated Providers Policy.

4.6 Rights and Obligations upon Termination.

(a) Continuation of Obligations. Upon termination, all rights and obligations of the parties under this Agreement shall immediately cease, except those rights and obligations that are identified as surviving the term of this Agreement. Termination of this Agreement shall not relieve either party of any obligation to the other party in accordance with the terms of this Agreement, and with respect to services furnished prior to such termination, and shall not relieve Provider of Provider's obligation to cooperate with PacificSource in arranging for the transfer of care of Members receiving treatment from Provider.

(b) Continuation of Services. If required by a Health Benefit Plan, and unless PacificSource makes provision for the assumption of such services by another practitioner, following termination of this Agreement, Provider shall continue to furnish, and PacificSource shall continue to pay for, in accordance with the terms of this Agreement, Covered Services rendered to Members under the care of Provider at the time of termination until the services being rendered are completed. PacificSource shall use its best efforts to arrange for any Members under the care of Provider at the time of termination of the Agreement to be transferred to another PacificSource Provider at the earliest possible date. In the event of termination of this Agreement, Provider shall cooperate with and not

interfere in the transfer of Members under the care of Provider at the time of termination until the services being rendered are completed.

(c) Access to Records Upon Termination. Notwithstanding any termination of this Agreement, Provider shall continue to provide PacificSource access to Provider's records, so as to allow PacificSource to continue to meet its obligations under the CCO Contract.

5.0 OREGON HEALTH PLAN PROVISIONS

5.1 Accountability. Provider acknowledges that PacificSource oversees and is ultimately accountable to OHA for the timely and effective performance of PacificSource's duties and responsibilities under PacificSource's contract with the State of Oregon, acting by and through OHA.

5.2 Continuation of Services. In the event of insolvency or cessation of operations of PacificSource, Provider shall continue to provide Covered Services to Members for the period in which PacificSource continues to receive compensation for administering services under the Oregon Health Plan.

5.3 Incorporation of Provisions. To the extent that any provision of PacificSource's CCO Contract to implement and administer services under the Oregon Health Plan applies to Provider with respect to the services contemplated hereunder, such provision shall be incorporated by this reference into this Agreement and shall apply equally to Provider.

5.4 Monitoring of Services PacificSource has the right to monitor the performance of Provider under this Agreement on an ongoing basis under the terms and conditions of this Agreement. Such monitoring may include routine and random audits and PacificSource shall have the right to interview Provider's consultants providing services hereunder as well as Provider staff and employees, subject to the provisions of any applicable collective bargaining agreement. Such monitoring of Provider's services will include the following: (a) an assessment of the quality of Provider's performance of contracted work; (b) any complaints or grievances filed in relation to Provider's work; (c) any late submission of reporting deliverables or incomplete data; (d) whether Provider's employees are screened and monitored for federal exclusion from participation in Medicaid; (e) the adequacy of Provider's compliance functions; (f) any deficiencies that OHA identified related to Provider's work; and (g) compliance with all applicable state and federal rules and the CCO Contract. Upon identification of deficiencies or areas for improvement, PCS shall cause Provider to take Corrective Action.

6.0 GENERAL PROVISIONS.

6.1 Reimbursement; Value-Based Payments. The parties recognize that the CCO Contract requires transition to value-based payments and agree to use best efforts to work together to establish and implement value-based benefits in a manner that allows PacificSource to fulfill the requirements of the CCO Contract by or before January 1, 2020, including performance measures determined by OHA or in discussions with OHA. Further, the parties agree to use best efforts to continue to work together to expand value-based

payments beyond January 1, 2020, again to allow PacificSource to fulfill the requirements of the CCO Contract and value-based payment requirements.

6.2 Non-Exclusivity. This Agreement is not exclusive, and nothing herein shall preclude either party from contracting with any other person or entity. PacificSource makes no representation or guarantee as to the number of Members who may select Provider for the purpose of receiving Covered Services.

6.3 No Third Party Beneficiaries. No Third Party Beneficiaries. PacificSource and Provider are the only parties to this Agreement and the only parties entitled to enforce its terms; provided, however, that OHA and other government bodies have the rights specifically identified in this Agreement. The parties agree that Provider's performance under this Agreement is solely for the benefit of PacificSourcto fulfill its CCO Contract obligations and assist OHA in accomplishing its statutory mission. Nothing in this Agreement gives, is intended to give, or shall be construed to give or provide any benefit or right, whether directly, indirectly or otherwise, to third persons any greater than the rights and benefits enjoyed by the general public unless such third persons are individually identified by name herein and expressly described as intended beneficiaries of the terms of this Agreement. This provision shall survive the termination of this Agreement for any reason.

6.4 Indemnification. Subject to ORS Chapter 30, during the term of this Agreement, Provider shall indemnify, defend, and hold PacificSource and PacificSource's employees and agents harmless from and against any and all claims, damages, causes of action, costs, or expenses, including reasonable attorneys' fees, to the extent proximately caused by the gross negligence or willful misconduct of Provider or any employee or agent of Provider's arising out of this Agreement. At all times during the term of this Agreement, PacificSource shall indemnify, defend, and hold Provider and Provider's employees and agents harmless from and against any and all claims, damages, causes of action, costs or expenses, including reasonable attorneys' fees, to the extent proximately caused by the gross negligence or willful misconduct of PacificSource or any PacificSource employee or agent arising from this Agreement. Notwithstanding the foregoing, this Section shall be null and void to the extent that it is interpreted to reduce insurance coverage to which either party is otherwise entitled, by way of any exclusion for contractually assumed liability or otherwise.

6.5 Dispute Resolution. Notwithstanding any other provision in this Agreement, and unless otherwise required by state or federal law, the parties agree to mediate disputes related to the termination or non renewal of this Agreement, through the mediation process detailed in OAR 410-141-3269. If mediation is unsuccessful, either party shall seek any available legal remedies through an action filed in the Circuit Court of Marion County.

6.6 Assignment. Neither party may assign or transfer its rights or obligations under this Agreement without the prior written consent of the other; provided, however, that PacificSource may assign this Agreement, upon thirty (30) days prior written notice, to any entity that controls, is controlled by, or that is under common control with PacificSource now or in the future, or which succeeds to its business through a sale, merger, or other corporate transaction without the prior consent of Provider. Any purported assignment or transfer in violation of this Section 6.6 shall be null and void.

6.7 **Amendments.** PacificSource may amend this Agreement or Exhibits necessary for compliance with state or federal law or regulation, which shall become effective upon notice from PacificSource to Provider if required by federal or state law. In the event Provider objects to such amendment necessary for compliance with state or federal law, PacificSource may, at its sole option, either continue this Agreement unamended or terminate this Agreement sixty (60) days from the date of receipt of written objection from Provider. During said sixty (60) day period, the terms and conditions of this Agreement as existed on the day prior to the date of the written objection, including all terms and conditions of compensation, shall continue to be in effect. If amendment is to comply with state or federal law, termination of this Agreement under this provision shall be treated as a "voluntary termination" without right to hearing. Notwithstanding the foregoing, this Agreement may be amended at any time by mutual written agreement signed by both parties.

6.8 **Headings.** The headings of the various sections of this Agreement are merely for convenience and do not, expressly or by implication, limit, define, or extend the terms of the sections to which they apply.

6.9 **Notices.** Any notice required to be given pursuant to the terms of this Agreement shall be in writing and shall be either hand delivered, sent via facsimile, sent via overnight mail (such as Federal Express), or sent postage prepaid, by certified mail, return receipt requested, to PacificSource or Provider at the address set forth on the signature page of this Agreement. Such address may be changed by giving notice of such change in the manner provided in this Section for giving of such notice. The notice shall be effective on the date of delivery if delivered by hand or sent via facsimile, the date of delivery as indicated on the receipt if sent via overnight mail, or the earlier of the date indicated on the return receipt or four (4) business days after mailing if sent by certified mail.

6.10 **Severability; Conformity with Law.** If any provision of this Agreement is declared invalid or otherwise unenforceable, the enforceability of the remaining provisions shall be unimpaired, and the parties shall replace the invalid or unenforceable provision with a valid and enforceable provision that reflects the original intention of the parties as nearly as possible in accordance with applicable law. This Agreement shall be interpreted and, if necessary, amended to confirm with applicable federal and state law in effect on or after its Effective Date.

6.11 **Waiver of Breach.** The waiver of any breach of this Agreement by either party shall not constitute a continuing waiver or a waiver of any subsequent breach of either the same or any other provision of this Agreement.

6.12 **Modification of Health Benefit Plan.** PacificSource may change, revise, modify, or alter the form or content of any Health Benefit Plan or Member written materials without prior approval or notice to Provider.

6.13 **Conflict with Health Benefit Plan; Outside Contracts.** This Agreement does not modify the benefits, terms, or conditions contained in a Member's Health Benefit Plan. In the event of a conflict between this Agreement and the terms of the Member's Health Benefit Plan, the terms of the Member's Health Benefit Plan shall control. PacificSource does not and shall not prohibit a Member from contracting for services outside the Member's

Health Benefit Plan; however, PacificSource does not consent to, or agree to be bound by, any terms or conditions that may be offered to, or entered into by, any Member contracting outside of their Health Benefit Plan

6.14 Conflict with PacificSource Provider Manual. In the event the terms and conditions of this Agreement conflict with the terms and conditions of the PacificSource Provider Manual, the terms and conditions of this Agreement shall control.

6.15 Governing Law. This Agreement shall be construed and enforced in accordance with the laws of Oregon. Any action commenced in connection with this contract shall be in the Circuit Court of Marion County.

6.16 Entire Agreement. This Agreement and any and all recitals, amendments, exhibits, attachments, schedules, and contain the entire agreement of the parties, and supersede any other agreement between the parties for Medicaid.

IN WITNESS WHEREOF, the parties hereto have entered into this Agreement as of the date first set forth above.

PACIFICSOURCE:

PacificSource Community Solutions

By: Sharon Thomsen, EVP

for Name: Peter McGarry Sharon Thomsen

Title: VP Provider Network

Date: 8/22/2019

PROVIDER:

Marion County, a political subdivision of the State of Oregon

Board of Commissioners:

Chair:

Commissioner:

Commissioner:

Date: 8-21-2019

Address:

PacificSource Community Solutions

PO Box 7469

Bend, OR 97708

Attn: Provider Contracting

Address:

Marion County, a political subdivision of the State of Oregon

1660 Oak St. SE

Salem, OR 97301

Schedule of Attachments and Exhibits

Attachment A-1, A-2	Reimbursement Schedules
Attachment B-1, B-2, B-3	Scope of Work and Special Provisions
Attachment C	Scope of Work and Special Provisions
Attachment D	Credentialing
Attachment E	Oregon Health Plan (Oregon Health Authority) Contractual Requirements
Exhibit 1	Required Federal Terms and Conditions

Attachment A-1

Marion County, a political subdivision of the State of Oregon

January 1, 2020

Reimbursement Schedule – Risk/Incentive Model

Community Mental Health Program

1.0 Risk/Incentive Model

The 2020 Risk/Incentive model agreed upon by PacificSource and Provider, and to be implemented on January 1, 2020, shall contain the following:

(A) A risk/incentive model involving multiple community Health Care Budgets for populations of Members assigned to specific physical health primary care providers, derived from revenue allocated for the physical health and behavioral/chemical dependency health care needs of Members, and a settlement for providers with budget-based aligned incentives as indicated in this Attachment.

(B) Fee-for-service payment for professional services provided by Provider with a Claims Risk Withhold, in addition to program-based PMPM reimbursement where appropriate.

(C) For distinct OHP Member populations assigned to physical health primary providers with risk/incentive models in their agreements with PacificSource, a risk/incentive model which features Revenue and Expenses for physical health and behavioral health/chemical dependency professional and residential services under OHP and paid by the State of Oregon to PacificSource as a global capitation payment, and less revenue reductions pertaining to (i) ABA Therapy and Hepatitis C reconciliations (as reconciled with the State of Oregon if necessary), (ii) HRA adjustments, taxes, premium transfers and other OHA mandated premium reductions, and (iii) excluding Revenue and Expenses in the following categories:

State of Oregon mandated spending/expenses on social determinants of health.

"Dental Care" premium allocation and expenses until such time as this premium and expenses are added to risk model described here.

"Non-Emergent Medical Transportation" premium allocation and expenses.

CCO Quality Incentive Measure ("QIM") withhold return from the State of Oregon received in the year of settlement, whose distribution methodology is excluded as determined by the CCO Health Council.

Operating payments to the CCO Health Council, taxes, adjustments and premium transfers.

(D) Contract terms that are consistent with the Joint Management Agreement (JMA) and JMA budget signed between PacificSource and the CCO Health Council which specifies the rules, duties, obligation, limitations on PacificSource margin, "Health Services" allocations, and other obligations and expenses for PacificSource as a CCO.

(E) Metrics which specify the return of part or all of the Risk Withhold and Surplus which may result from health care expenses measured against a Health Care Budget.

2.0 Compensation

2.1 Fee For Service Reimbursement

For services listed in this Fee For Service Reimbursement section and provided from the effective date of this Agreement through 12/31/2020, Provider shall be guaranteed a minimum payment equivalency of $5.16 PMPM based on full CCO (not county-specific) membership eligible for mental health benefits. Total FFS payments and total membership shall be reconciled for services provided during the time period identified, and, if FFS payments plus withhold amounts to Provider are less than this minimum payment, then the difference will be paid by PacificSource to Provider within seven (7) months after the end date of the reconciliation period.

SERVICE/PROCEDURE	MAXIMUM ALLOWABLE
Outpatient Behavioral Health Assessments: Codes listed below	**160%** of current OHP Allowable Amount[1, 2]
Evaluation and Management Services: Codes listed below	**160%** of current OHP Allowable Amount[1, 2]
Other Outpatient Mental Health Services: Codes listed below	**130%** of current OHP Allowable Amount[1, 2]
Other Outpatient Substance Use Disorder Services: Codes listed below	**130%** of current OHP Allowable Amount[1, 2]
Laboratory, DME/supplies	**100%** of current OHP Allowable Amount[1, 2]
Drugs, Injections, Vaccines, Immunizations	**100%** of current OHP Allowable Amount[1, 2]
Services and Procedures not otherwise listed in this Attachment	**100%** of current OHP Allowable Amount[1, 2] or, if no OHP Allowable Amount, PacificSource Community Solutions Default Fee Allowance[3]

[1] Payment will be based on the lesser of the billed amount or PacificSource rates in effect at the time service or supplies are rendered or provided as specified above.

[2] PacificSource will reimburse based on the rates published as of the date of adjudication.

[3] PacificSource utilizes industry standard publications and rate methods to supplement codes not established by the above noted methodologies.

Outpatient Behavioral Health Assessment codes: 90791, 90792, 96130-96137, H0001, H0031, H2000
Evaluation and Management Services: 99201-99205, 99211-99215, 99354, 99355, 99341-99345, 99347-99350
Other Outpatient Mental Health Services codes: 90785, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90846, 90847, 90849, 90853, 90882, 90887, 90889, 96150-96154, H0032, T1023, T2010, T2011
Other Outpatient Substance Use Disorder Services codes:

H0002, H0004, H0005, H0006. H0020, H0022, H0033, T1006

Fee For Service Reimbursement – Traditional Healthcare Workers (THWs)

SERVICE/PROCEDURE	MAXIMUM ALLOWABLE
All Medical Services: As defined in the OHP Medical-Dental Fee Schedule	**100**% of current OHP Allowable Amounts [1,2]
Anesthesia: Service or supply with an ASA value	**100**% of current OHP Allowable Amounts [1,2,3]
Laboratory, DME/supplies	**100**% of current OHP Allowable Amounts [1,2]
Drugs, Injectables, Vaccines, Immunizations:	**100**% of current OHP Allowable Amounts [1,2]
Services and Procedures without an established unit value	PacificSource Community Solutions Default Fee Allowance[4]

NOTE: Payment will be based on the negotiated rates in effect at the time the services or supplies are rendered or provided as specified above. Payment will be the lesser of Providers billed charges or the Maximum Allowable indicated herein.

1. PacificSource will reimburse based on the rates published as of the date of adjudication.
2. Updates to the schedules noted above shall be updated in accordance with the state of Oregon, OHA and HSD.
3. ASA Basic Unit Value and annual updates as defined by the American Society of Anesthesiologists Relative Value Guide. Time units shall be based on 15 minute increments.
4. PacificSource utilizes industry standard publications and rate methods to supplement codes not established by the above noted methodologies.

2.2 Claims Risk Withhold

Claims payments to Provider for the services above shall have ten percent (10%) of the Allowed Compensation withheld as a Claims Risk Withhold.

2.3 Program-Based Reimbursement

Reimbursement for the services and programs defined below will be calculated as a per-member per-month (PMPM) payment of $10.13 based on full CCO (not county-specific) membership eligible for mental health benefits. The PMPM payment will be made prospectively based on the rates listed below with retroactive reconciliation as described below completed by PacificSource based on quarterly Provider reports using PacificSource's reporting template.

Services and Programs	Unit of Measure	$ per Unit	Budgeted Units (not to exceed)	Estimated Annual Payment	Actual Payment PMPM
Local Public Health Authority Services	n/a	n/a			$0.31
Local Mental Health Authority Services (i.e.	n/a	n/a			$0.12

Services and Programs	Unit of Measure	$ per Unit	Budgeted Units (not to exceed)	Estimated Annual Payment	Actual Payment PMPM
residential care coordination, civil commitment, system coordination)					
Children's Wraparound Care Coordination	Per team (15 youth)	$200,000	10.3	$2,060,000	$1.65
Professional Supervision for Licensure	Per trainee	$6,000	20	$120,000	$0.10
Community Support Services (CSS) Total	n/a	n/a			$7.95
Total Program Support	n/a	n/a			**$10.13**

Allocation of payment for Community Support Services[4]					
Crisis (including Mobile)					$2.09
Supported Employment-Education					
Early Psychosis including EASA					
Assertive Community Treatment					
SPMI Services					
Intensive Children's Services					
Other CSS: Her Place, LEAD					

Services and Programs	Description, Conditions, and Reporting
Community Support Services (CSS) Total	[4]Allocation of Program Support payment across CSS will be calculated or recalculated during the third quarter of each calendar year based on Provider's prior fiscal year budget and actual financials. Reporting: Actual expenditures, enrollment, performance, and outcomes.
Professional Supervision for Licensure	Description: Trainee is defined as a Mental Health Intern or an individual who has completed required academic degree for practice and is being supervised by a Provider employed or contracted clinician under a board-approved supervisory agreement in a clinical mental health field. Reporting: Quarterly roster of eligible trainees by name with clinical hours accrued quarterly and each trainee's total hours of supervision completed. Payment: Average monthly Full Time Equivalent trainees over the quarter will be calculated. Future years' payments will be adjusted based on this reporting process.

Services and Programs	Description, Conditions, and Reporting
Children's Wraparound Care Coordination	Total capacity 170 youth. Estimate 90% of enrolled clients (capacity 155) will be CCO members, averaged over course of the calendar year. Future years' payments will be adjusted if Provider reporting indicates actual enrollment that deviates significantly and persistently from this estimate.
Assertive Community Treatment (ACT)	Capacity of 79 enrolled individuals with an estimated 70% of clients being CCO members. PCS and Provider shall collaborate to monitor ACT need, enrollment, and capacity in the region in order to make good use of available capacity and not waitlist any eligible clients. If PCS and Provider agree that Provider will increase its capacity through adding a team serving up to 40 clients, PCS will add $0.58 PMPM to the Program Support payment to Provider.

The following codes will be encountered at 100% of OHP fee schedule or, when not listed on the OHP fee schedule, PacificSource Community Solutions Default Fee Allowance, but these codes will not be paid because their value is included in the Program payments detailed above:

Crisis	H2011, S9125, S9484, T1015
Training/Skills/Case Management	G0176, G0177, H0036, H0038, H0039, H0046, H2014, H2018, H2021, H2022, H2023, H2027, H2032, H2033, T1016
Medical services – within scope of nursing staff	H0034, H2010

2.4 Settlement Parameters

Provider understands and agrees to be subject to the settlement terms pertaining to Risk Withhold return and Surplus distribution, of other primary care provider agreements when providing services for OHP Members assigned to other primary care providers, and when providing services for OHP Members assigned to other primary care providers of other CCOs.

2.5 Surplus Distribution and Risk Withhold Return Contingent On Quality.

One hundred percent (100%) of any Surplus distribution and Provider's Risk Withhold return will be paid contingent on the Performance Measures as listed below and as negotiated on an annual, calendar year basis.

3.0 Premium Allocation

The following allocation of premium is part of the PacificSource budget-based aligned incentive structure:

3.1 Definition.

3.1.1 Estimated Earned Net Premium Revenue. Estimated Earned Net Premium Revenue shall be determined in the risk/incentive contract between PacificSource and the Member's assigned physical health primary care provider, but will generally consist of those global capitation payments (including adjustments) and reconciliations with the State of Oregon, received by PacificSource from the State of Oregon, less premium reductions in Section 1 which include: OHA-required Hepatitis C and ABA therapy reconciliation adjustments with the State of Oregon if necessary, OHA qualified and directed pass-through payments, Managed Care taxes, PacificSource income taxes, other state or federal taxes (HRA/GME/MCO/Provider), Hospital Reimbursement Adjustments (HRAs), Dual Eligible Medicare Premium Transfers, any OHA-mandated premium reductions, OHA-mandated Social Determinants of Health (SDOH) spending, Dental Care premium allocation to DCOs, Non-Emergent Transportation premium allocation, operating payments to CCO Health Council, and some portion of QIM risk withhold return per the agreement of the CCO Health Council.

3.2 Allocation of Estimated Earned Net Premium Revenue.

The remaining Estimated Earned Net Premium Revenue will be allocated as follows:

3.2.1 Administration. Eight and seventy hundredths percent (8.70%) of the remaining Estimated Earned Net Premium Revenue shall be allocated to PacificSource for administration and limited margin.

3.2.2 Amount Allocated to the Health Care Budget (HCB). Ninety-one and thirty hundredths percent (91.30%) of the remaining Estimated Earned Net Premium Revenue shall be allocated to the Health Care Budget.

4.0 Allocations and Disbursement

4.1 Computation of Budget Expenses.

Expenses will be determined in the risk/incentive model in the agreement between PacificSource and the Member's physical health primary care provider, but will generally include: All physical health and behavioral health claims expenses (including Risk Withhold), PMPM provider fees (including any PCPCH and CPC+ expenses), hospital/facility expenses, reinsurance/stop loss premium expenses (less recoveries), Pharmacy Expenses (less rebates), PCP Capitation Expense, subrogation adjustments, premium/MCO taxes, coinsurance expenses, out-of-area expenses, ancillary expenses, Traditional Healthcare Workers (THWs) expenses, Health Services and other expenses iterated in the Joint Management Agreement (JMA) and JMA budget between PacificSource and CCO, and Community Benefit and Flexible Services expenses shall be charged to the Health Care Budget based on the day services were actually rendered with the exception of Late Claims, as defined below, which shall be charged to the next year's applicable budget.

4.2 Disposition of Late Claims.

Late Claims are those claims received, processed, and paid later than four months (120 days) after the close of the contract period. Late Claims will be attributed to the next year's applicable budget.

5.0 Settlement Parameters

5.1 Settlement Parameters

The following settlement parameters for this section pertain for OHP members assigned to physical health primary care providers with risk/incentive models in their agreements with PacificSource. Provider understands and agrees to be subject to the settlement terms pertaining to surplus distribution and Risk Withhold return, of these other physical health provider agreements when providing services for OHP Members assigned to other providers, and assigned to other providers of other CCOs.

5.2 Time Period.

Annual Claims Risk Withhold settlement will occur for the calendar year four months (120 days) after the close of the contract period ending December 31st. Any charges/credits to the applicable budgets that have occurred since the settlement of the previous contract period are accounted for in the settlement of the current period. Claims Risk Withhold return will be mailed to Provider no later than forty-five (45) days after final OHA determinations of QIM revenue determinations and any OHA decisions on any revenue reductions which could be applied retroactively to the beginning of the contract period.

5.3 Claims Risk Withhold Settlement Summary.

PacificSource shall be responsible for computing, documenting, and reporting to Provider an annual Claims Risk Withhold settlement summary. This report shall be submitted to Provider approximately five months (151 days) after year-end.

5.4 Budget Surplus or Deficit

For the contract period for the experience of Members assigned to any physical health primary care provider with a risk/incentive model in their agreement with PacificSource, the Health Care Budget will be compared to actual expenses incurred to determine whether a Surplus or Deficit exists.

5.4.1 Surplus.

If the total value of total covered claims and expenses, including Claims Risk Withhold, is less than the HCB, a Surplus exists. Surplus distributions will be limited to a percentage of the Surplus amount. The non-distributed portion of Surplus will be treated as Shared Savings under the terms of the JMA. In the event of a Surplus payment, Surplus and Claims Risk Withhold may be returned to Provider depending on Quality Improvement Metric (QIM) performance. Surplus amounts may be distributed as a percentage depending on practitioner type, and amount of risk withhold accrued from Provider, with Provider's and any other provider's Surplus payment limited to three hundred percent (300%) of Provider's or any other provider's Risk Withhold amount.

5.4.2 Surplus Distribution and Risk Withhold Return Contingent On Quality.

One hundred percent (100%) of the surplus distribution and Risk Withhold return will be paid contingent on the performance of the CCO QIMs, the majority of which are established and measured by the State of Oregon for the entire CCO and will be awarded based on such State of Oregon measurement and State of Oregon final payment to PacificSource.

5.4.3 Surplus Distribution and Claims Risk Withhold Return – Value Based Payment.
Provider will cooperate with PacificSource in complying with OHA requirements for value-based payments in the areas of: Maternity, Hospital, Pediatric, Behavioral Health and Oral Health care. As such, Surplus Distribution and Claims Risk Withhold return may be contingent on a specific array of metrics pertaining to these OHA-required areas as determined by PacificSource and Provider.

5.4.4 Unearned Surplus and Risk Withhold
Any Unearned Risk Withhold and surplus shall be allocated in the following manner:

1st Used to contribute to PacificSource's limited margin, consistent with the limitation in the Joint Management Agreement (JMA) between PacificSource and the CCO Health Council.

2nd Any remaining Unearned Surplus Payment will be treated as shared savings under the terms of the JMA.

5.4.5 Deficit
If the value of total covered claims and expenses, including Claims Risk Withhold, is more than the Health Care Budget, a Deficit exists, and Claims Risk Withhold from all providers will be used to satisfy the Deficit, at an equal percentage from all providers. Any Claims Risk Withhold remaining after the Deficit has been reduced to zero dollars ($0.00) will be returned to providers as an equal percentage for all providers from whom Claims Risk Withhold was taken, consistent with performance of CCO QIMs. Any remaining Deficit after application of Claims Risk Withhold will be satisfied by PacificSource.

6.0 Performance Measures and Reporting

6.1 Performance Measures
For calendar year 2020, any Surplus and Risk Withhold Distribution to Provider shall be based on the below, with the weight of each performance measure representing the percentage of return to be paid based on achieving the measure.

6.2 Performance Reports.
Performance measure reports from Provider shall be submitted using PacificSource's ShareFile site by 11:59pm on the due date stated. Late submissions will incur a 25% penalty on weighted performance withhold value per partial or full week that reporting is submitted after the due date.

#1: Quality Improvement Measures (QIMs) as specified by OHA: https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Metrics.aspx: a. Assessments for children in DHS custody; b. Depression Screening; c. SBIRT; d. Emergency Department Use for members with mental health conditions, e. Smoking prevalence; f. Initiation-Engagement-Treatment for Substance Use Disorders	
Goal	CCO achieves performance targets as determined by the Metrics and Scoring Committee and OHA via the State Quality Pool
Weight	60% (10% each measure)
Reporting	PacificSource data
Target	CCO passes QIM per OHA
Numerator	Per OHA specifications
Denominator	Per OHA specifications
#2: Member/Client Experience	
Goal	Assess and/or improve member experience in accessing or receiving care.
Weight	20%
Reporting	TBD
Target	TBD
Numerator	TBD
Denominator	TBD
#3: Organizational Quality Goal TBD	
Goal	Improve the quality, efficiency, and/or scope of Provider's clinical services.
Weight	20%
Reporting	TBD
Target	TBD
Numerator	TBD
Denominator	TBD

7.0 GENERAL PROVISIONS.

7.1 Requirements

Provider will participate in and attest to performing (a) data submission activities pertinent to CCO eCQMs EHR-based incentive metrics, (b) data submission requirements including sending accurate data in time and formats determined by CCO to comply with OHA measure specifications, (c) submitting eCQM data to PacificSource on a monthly basis by the 20th of the month, (d) requests for surveys or other information, (e) requests to complete successful CCO data collection/submission activities, and (f) reporting expectations for eCQMs for diabetes, hypertension, depression, SBIRT, tobacco prevalence, BMI and any additional eCQM determined by OHA. Provider acknowledges that submission of these requirements is essential as failure to do so for each EHR-based incentive will lead to failure for each eCQM measure, failure to meet the population threshold required, and will cause the CCO to fail the measure.

Provider will perform patient satisfaction surveys in alignment with PCPCH standard requirements, and will share such survey results with PacificSource upon reasonable request.

Provider will cooperate with PacificSource on PacificSource's CAHPS Improvement Plans.

Provider allow PacificSource to share individual provider QIM performance with CCO Health Councils.

Provider will collaborate with PacificSource to gain consensus through the CCO Health Council on maximizing and distributing Quality Pool funds from OHA.

Provider will collaborate with PacificSource to comply with the OHA Health Plan Quality Metrics Committee (HPQMC), with PacificSource responsible for describing quality metrics from the HPQMC that will be used.

Provider will collaborate with PacificSource to comply with OHA's Practitioner Incentive Plan (PIP) reporting.

Provider will cooperate with PacificSource to collaborate on fulfilling any OHA requirements in the increased adoption of Health Information Exchange (HIE), Health Information Technology (HIT), and Electronic Health Record (EHR) technology.

7.2 Oregon Health Plan/OHA Capitation Administration Regulations

In the event of (a) new or changing requirements, rules, regulations or guidance related to applicable provider capitation payments made by PacificSource to Provider, and per PacificSource Exhibit L filing and Medical Loss Ratio filings submitted to OHA, and/or (b) PacificSource's and/or OHA's interpretation of applicability of such requirements, rules, regulations, or guidance and applicability of PacificSource's capitation payment methodology with Provider, PacificSource may enact the following:

- A charge commensurate with any OHA recoupment, demand for repayment, charge, tax or fee, to be charged against the CCO Health Care Budget, and/or
- A renegotiation with Provider to revert all payment methodologies entailing Provider capitation, to a fee-for-service payment methodology.

Provider shall cooperate with PacificSource to produce reports for PacificSource and/or OHA that satisfy to PacificSource and OHA discretion, the requirements, rules, regulations or guidance from OHA related to capitation payments.

7.3 Oregon Health Plan/OHA Possible Premium Revision / MLR-based repayment to OHA

In the event of a revision of premium levels for OHP members by the State of Oregon/OHA by a net amount deemed by PacificSource to be inconsistent with the reimbursement agreed to in this 2020 Agreement, PacificSource will notify Provider of such inconsistency in writing, and both parties will enter into a renegotiation of 2020 reimbursement rates to achieve consistency with any new Oregon PacificSource/OHA premium levels.

In the event OHA determines PacificSource must pay OHA any sum because the CCO Medical Loss Ratio (MLR), as determined by OHA, does not meet a minimum threshold for the entire population or any benefit-category specific sub populations, PacificSource reserves the right to (a) deduct a pro-rata portion of such repayment from the Health Care Budget in Section 6, or (b) make direct investments to increase the MLR and offset such expenses with the settlement, upon communication with Provider and the CCO Health Council.

7.4 MLR Reporting for 2020.

Provider shall submit to PacificSource a report for each clinic for the cost year January 1, 2020 – December 31, 2020 no later than March 30, 2021 using a format accepted by OHA. Provider shall refer to "2020 Medical Loss Ratio Rebate Instructions" (as published on the OHA CCO Contract Forms website at http://www.oregon.gov/oha/healthplan/Pages/cco-contract-forms.aspx) for support.

7.5 Health Related Services (Flexible Services and Community Based Health-Related Services.

Consistent with the Health-Related Services Rule adopted by the OHA (which include member-level disbursements often called "flexible services", and community-based Health-Related Services, often called "Community Benefit Initiatives") and the Health-Related Services Brief released by the OHA, along with PacificSource policies approved by OHA, PacificSource will make certain disbursements from the Health Care Budgets from time to time and at PacificSource's discretion. These disbursements are distinct from PacificSource-provided Health Services.

7.6 Community Health Improvement Plan, Transformation Plan and Health Council Activities.

Provider will collaborate with PacificSource, the CCO Health Council, and other stakeholders in completing a Community Health Assessment (CHA) and a Community Health Improvement Plan (CHIP), and in carrying out activities to implement the CHIP including any recommendation tied to community access studies. Provider will collaborate with PacificSource, the CCO Health Council, and other stakeholders to carry out the Transformation And Quality Strategies. For purposes of the CHA, CHIP, or Transformation And Quality Strategies, for reporting to the CCO Health Council or any of its subcommittees, or for reporting to OHA, PacificSource may share Provider utilization, membership numbers, and additional performance data. Provider will collaborate with PacificSource and the CCO Health Council to meet Transformation And Quality Strategies requirements and participate in Transformation And Quality Strategy projects.

7.7 Corrective Action Plans

PacificSource, at its sole discretion and consistent with expectations of PacificSource by OHA, may determine that Provider performance of obligations, duties and responsibilities under the terms of this Agreement is deficient. In reaching that conclusion, PacificSource may, but is not required to consider third-party audit or other formal review results, peer review results, quality measures, written or oral feedback from members or patients, and any other issues which may be identified by PacificSource. If PacificSource determines Provider performance is deficient for any reason, but that such deficiency does not constitute a Material Breach of the terms of this Agreement, PacificSource may institute a corrective action plan ("CAP") subject to internal review. PacificSource will notify Provider of the terms of the CAP and will provide a CAP reporting template. PacificSource will supply supporting information/data to Provider at that time. Provider shall have thirty (30) days to resolve the CAP to PacificSource's satisfaction. Failure to resolve the CAP shall constitute a Material Breach by Provider, and PacificSource may terminate this Agreement immediately.

7.8 Value-Based Payment

Provider agrees to participate in PacificSource's Value-Based Payment (VBP) program, consistent with OHA requirements for the five year period from 2020-2024 in which an increasing portion of provider payment conforms to the Learning and Action Network (LAN) category 2C or higher, which may entail the following elements.

- Payment based on any of the above methodologies
- Payment Withhold
- Surplus sharing
- Payment models to support care transformation and quality improvement in the following areas:

  Hospital Care
  Maternity Care
  Children's Care
  Behavioral Health Care
  Oral Health Care

In collaboration with Provider, PacificSource will share with Provider information pertaining to Health Information Technology (HIT) to support success in effective participation with the VBP program.

8.0 Miscellaneous

8.1 Defined Terms

Any terms not otherwise defined herein shall have the meaning set forth in the Participating Provider Agreement.

8.2 Precedence

Any conflict or inconsistency shall be resolved by giving precedence to this Attachment first, then to Attachment B, and then to the Participating Provider Agreement

Attachment A-2
Reimbursement Schedule
Public Health

Effective January 1, 2020

These rates shall apply to all PacificSource Community Solutions Networks and Products

1.0 Fee For Service Reimbursement

SERVICE/PROCEDURE	MAXIMUM ALLOWABLE
All Medical Services listed in B-2 As defined in the OHP Medical-Dental Fee Schedule	**100**% of current OHP Allowable Amounts [1,2]
Anesthesia: Service or supply with an ASA value	**100**% of current OHP Allowable Amounts [1,2,3]
Laboratory, DME/supplies	**100**% of current OHP Allowable Amounts [1,2]
Drugs, Injectables, Vaccines, Immunizations:	**100**% of current OHP Allowable Amounts [1,2]
Services and Procedures without an established unit value	PacificSource Community Solutions Default Fee Allowance[4]

NOTE: Payment will be based on the negotiated rates in effect at the time the services or supplies are rendered or provided as specified above. Payment shall be the lesser of Provider's billed charges or the Maximum Allowable amount.

1. PacificSource will reimburse based on the rates published as of the date of adjudication.
2. Updates to the schedules noted above shall be updated in accordance with the state of Oregon, OHA and HSD.
3. ASA Basic Unit Value and annual updates as defined by the American Society of Anesthesiologists Relative Value Guide. Time units shall be based on 15 minute increments.
4. PacificSource utilizes industry standard publications and rate methods to supplement codes not established by the above noted methodologies.

Attachment B-1

Scope of Work and Special Provisions – Behavioral Health and Community Mental Health Programs

Effective January 1, 2020

1. Scope of Work – Certificate of Approval

Provider is contracted to perform work that may encompass services covered under one or more Certificates of Approval (COA) issued by the Oregon Health Authority. Provider certifies that Provider has active COAs as indicated by "X" in the left column of the table below. Provider will supply copies of COAs to PacificSource prior to execution of this Agreement and upon request. Provider will notify PacificSource immediately upon any change to the information listed below.

Active	Type of Certificate of Approval
X	Community Mental Health Program
X	Residential Substance Use Disorder & Problem Gambling Treatment
X	Outpatient Behavioral Health Services
X	Intensive Treatment Services for Children and Adolescents
	N/A - Provider does not hold and is not required to hold any Certificates of Approval.

2. Scope of Work – Local Mental Health Authority responsibilities

If Provider is a Community Mental Health Program designated by its Local Mental Health Authority (LMHA), then Provider is contracted to perform the following services required of an LMHA by OHA and per PacificSource's CCO contract with OHA:

2.1. Management of children and adults at risk of entering or who are transitioning from the Oregon State Hospital or from residential care;

2.2. Care coordination of residential services and supports for adults and children;

2.3. Management of the mental health crisis system including mobile crisis 24 hours a day on every day

2.4. Community-based specialized services:

(a) Supported Employment and Education

(b) Early Psychosis including Early Assessment and Support Alliance

(c) Assertive Community Treatment (ACT)

(d) Evidence-based intensive services for adult Members who refuse ACT services

(e) Intensive case management and home-based services for children

2.5. Management of specialized services to reduce recidivism of individuals with mental illness in the criminal justice system.

3. Scope of Work – Specific responsibilities

3.1. Delegated CCO Duties, subject to satisfactory completion of prior PacificSource audit of activity or, if not, completion of pre-delegation audit:

(a) Credentialing of Clinical Professionals

(b) Intensive Care Coordination

3.2. Evidence-based dyadic treatment for children

3.3. Outpatient Mental Health for Children and Adults, including (a) psychiatric consultation by physicians or nurse practitioners to community based providers, and (b) psychiatric care provided to clients under an access process not universally contingent on enrollment in psychotherapy services.

3.4. Wraparound Services for Children and Youth

3.5. Intensive Outpatient Services and Supports for Children and Youth

3.6. Peer delivered services

3.7. CANS assessments

3.8. Outpatient Substance Use Disorder Services

(a) Outpatient Substance Use Disorder Services (ASAM Level 1)

(b) Intensive Outpatient Substance Use Disorder Services (ASAM Level 2.1)

(c) Including services targeting the needs of the following special populations (for example: Adolescents; Women and women's specific issues; Ethnically and racially diverse group and environments that are culturally responsive and linguistically relevant; Intravenous drug users; Individuals involved with the criminal justice system; Individuals with co-occurring disorders; and Parents accessing residential treatment with any accompanying dependent children).

4. Description of Performance Responsibilities

4.1. For any items listed in the preceding Scope of Work sections, Provider shall meet the following conditions in accord with listed reference including the CCO Contract, meaning the Sample Oregon Health Plan Health Plan Services Coordinated Care Organization 2020 Contract and any subsequent revisions or replacement contracts, which can be accessed on the OHA website or from PacificSource upon request:

(a) Assertive Community Treatment (ACT) services shall be provided in accord with CCO Contract Exhibit M, Section 2.d and any subsequent amendments.

(b) Provider shall report ACT program data as detailed in the CCO Contract Exhibit M, Section 5 in a form and on a schedule to be specified by PacificSource.

(c) Crisis Services, including respite and mobile crisis team, shall be provided 24 hours a day every day and shall be provided in accord with CCO Contract Exhibit M, Section 2.g.

(d) Children's Wraparound Services shall be implemented in accord with CCO Contract, Exhibit M, Section 4, including the documents referenced in the section, and relevant PacificSource policy then in effect.

(e) Children's Wraparound Services shall be assessed the OHA-designated evaluation tools, including WFI-EZ and TOM 2.0, shall obtain at least 35% response rate on WFI-EZ, and shall report results using the designated Oregon State data collection system.

(f) Child and Adolescent Needs and Strengths screening shall be conducted with all Members under care with Provider in the situations specified in the CCO Contract, Exhibit M, Section 4 and shall be recorded in the designated Oregon State data collection system.

4.2. Intensive Care Coordination shall be provided as detailed in CCO Contract Exhibit M, Section 4.f. and subject to satisfactory completion of pre-delegation audit by PacificSource as a condition of payment for these services.

4.3. Provider shall provide services to established clients who are admitted to Acute Inpatient Psychiatric Facilities and a follow-up visit within seven (7) days of discharge consistent with Exhibit M, Section 5 of the CCO Contract.

4.4. Provider shall use health information technology to identify clients with more than two (2) emergency department visits in six (6) months and provide follow-up within three (3) days after the triggering visit.

5. Special Provisions

5.1. All services and supports shall be rendered in the most integrated community-based settings possible, consistent with the Member's choice, so as to minimize the use of institutional care. All services and supports shall be in accordance with all applicable state and federal requirements.

5.2. Provider shall ensure that its services consider, and do not bias against, the cultural differences of Members. This includes reporting of services provided that delineates by age, gender, ethnicity, disability, and other Member attributes, consistent with OAR 410- 141-3220.

5.3. If Provider is an LMHA-designated Community Mental Health Program, then Provider shall track all grievances communicated to Provider by a Member or Member representative and report to PacificSource.

5.4. If Provider is an LMHA-designated Community Mental Health Program, then Provider shall provide care coordination services to Members to assist their receipt of Covered Services or long term care services outside of those available from Provider. Services provided may include establishing pre-commitment service linkages, advocating for treatment needs, and providing assistance in obtaining entitlements based on mental or emotional disability. Provider shall arrange and coordinate with all provider types and social service agencies, regardless of inclusion with the status as Covered Services, on an ongoing basis. Such coordination shall include without limitation all Agency for People with Disabilities facilities in the Service Area, justice system, Department of Human Services, acute care facilities, outpatient behavioral health clinics, primary care clinics, physical health specialty clinics, substance abuse facilities, and any PacificSource Provider.

5.5. If Provider is an LMHA-designated Community Mental Health Program, then Provider shall facilitate ongoing communication and collaboration, including facilitating

communication between the family, natural supports, community resources, and involved providers and agencies; organizing, facilitating and participating in team meetings; and providing for continuity of care by creating linkages to and managing transitions between levels of care and transitions for young adults in transition to adult services.

6. General Provisions

6.1. Defined Terms – Any terms not otherwise defined herein shall have the meaning set forth in the Participating Provider Agreement.

6.2. Precedence – Any conflict or inconsistency shall be resolved by giving precedence first to this Attachment then to Attachment A then to the Participating Provider Agreement.

Attachment B-2

Marion County, a political subdivision of the State of Oregon

January 1, 2020

Scope of Work and Special Provisions - Public Health

1. **Scope of Work – Public Health Department/District responsibilities:**

   1.1 Physical health care services provided by Marion County may include those listed in the health care benefit package administered by PCS, and will be billed according to schedule A-2. Provider may discontinue the provision of any or all physical health care service upon 90 days notice to PCS.
   1.2 Recognize and address health inequities that are specific to certain populations.
   1.3 Engage diverse populations in community health planning.

2. PCS will support LPHAs efforts to develop strategic, cross-sector partnerships across systems and settings related to maternal and child health, communicable disease, substance use, suicide prevention and additional health priorities identified in the CHIP.

3. PCS will collaborate with LPHA in the event of a public health emergency. LPHA will provide efficient and appropriate situation assessment, determine objective for the health needs of those affected, and allocate resources to address those needs.

4. PCS will collaborate with LPHA to identify population subgroups or geographic areas characterized by an excess burden of adverse health or socioeconomic outcomes, an excess burden of environmental health threats, and/or inadequate health resources that affect health.

5. **Scope of Work – Additional responsibilities:**
   None

6. **Special Provisions:**
   PacificSource will collaborate with Marion County to conduct a regional Community Health Assessment and Community Health Improvement Plan and will make good faith effort that the product meets Provider's needs for health assessment and planning.

   PacificSource will support involvement of Provider representatives in CCO governance structure and workgroups.

   Provider shall be eligible for Quality Pool payments as detailed in Attachment A – Compensation or as determined by CCO.

7. **General Provisions**

   a. Defined Terms – Any terms not otherwise defined herein shall have the meaning set forth in the Participating Provider Agreement.

   b. Precedence – In the event of any conflict or inconsistency, it shall be resolved by giving precedence first to this Attachment B then to Attachment A then to the Participating Provider Agreement.

Attachment B-3

Scope of Work and Special Provisions – Traditional Healthcare Workers (THWs)

Effective January 1, 2020

1. Description of Performance Responsibilities

1.1 Provider shall:

(a) Track and document Member interactions with THWs,

(b) Collaborate in the integration of THWs into the delivery of services,

(c) Assist in communications to Members about the benefits of THW services,

(d) Assist in the implementation of THW Commission best practices,

(e) Assist in measuring baseline utilization and performance,

(f) Coordinate with the OHA office of Equity and Inclusion to implement best practices,

(g) Submit claims and encounter data for THW services in the clinic setting, non-clinic setting, and community-based settings,

(h) Collect data using the reporting template provided by OHA, including: Member satisfaction, ratio of THWs to Members, number of THWs employed, requests by Members for THW services, number of engagements by THWs are part of the Member's care team, demographics of THWs and CCO membership, and other data for each of the THW provider types including doulas, community health workers, peer support specialists, peer wellness specialists, and patient health navigators.

7. General Provisions

7.1. Defined Terms – Any terms not otherwise defined herein shall have the meaning set forth in the Participating Provider Agreement.

7.2. Precedence – In the event of any conflict or inconsistency, it shall be resolved by giving precedence first to this Attachment B then to Attachment A then to the Participating Provider Agreement.

Attachment C

Scope of Work and Special Provisions – All Providers

The following are required duties of Provider as detailed in the CCO Contract and Oregon Administrative Rules:

1. Provider shall assure that Traditional Health Workers, who are employed by Provider, have met the requirements for background checks for Traditional Health Workers, as described in OAR 410-180-0326 and will submit encounter data, workforce assessments, capturing non-encounterable services, and required reporting metrics for all services provided by Traditional Health Workers.
2. Provider and Provider's employees and subcontractors shall participate in PacificSource's offered training, technical assistance, and oversight on recovery principles, motivational interviewing, integration, and trauma informed care as required by the CCO Contract.
3. Provider shall participate in PacificSource's offered training on implicit bias as required by the CCO Contract.
4. Provider shall cooperate on OHA-required workforce reporting requirements, metrics, coordination of care coordination and care transition requirements, and other OHA requirements.
5. Provider shall screen all pregnant women for behavioral health needs at least once during pregnancy and at least once during the post-partum period and shall have a plan in place for follow-up and/or referrals as indicated by screening results.
6. Provider shall screen Members for adequacy of supports for the family in the home (e.g., housing adequacy, nutrition/food, diaper needs, transportation needs, safety needs and home visiting).
7. Provider shall conduct screening for all Members and provide prevention, early detection, brief intervention and referral to Substance Use Disorders treatment who are in any of the following circumstances:
    - 7.1. At an initial contact or during a routine physical exam;
    - 7.2. At an initial prenatal exam;
    - 7.3. When the Member shows evidence of Substance Use Disorders or abuse (as noted in the OHA approved screening tools); and/or
    - 7.4. When the Member over-utilizes Covered Services.
8. If Provider provides primary care services, then Provider shall periodically conduct socio-emotional screening for all children birth to age five and have a process to address in timely fashion any concerns found by the screening.
9. If Provider provides Substance Use Disorders services, then Provider shall provide to Members, to the extent of available community resources and as clinically indicated, information and referral to community services which may include without limitation child care, elder care, housing, transportation, employment, vocational training, educational services, mental health services, financial services, and legal services.

10. If Provider provides Behavioral Health services, then Provider shall:

    10.1. Assess for adverse childhood experiences, trauma, and resiliency in a culturally responsive manner, using a trauma informed framework in developing individual service and support plans for Members, and

    10.2. Provide OHA in a timely fashion with all data reporting required by OHA, using the OHA-specified data system(s).

    10.3. Engage in the integration of behavioral health and physical health services consistent with OHPB #18.

11. Appointment Availability. Provider shall report to PacificSource regarding appointment availability per a format consistent with OHA requirements and provided by PacificSource, and provide or otherwise make available to each Member timely treatment, in accord with the CCO Contract and, if not addressed in the CCO Contract, OAR 410-141-3220 as summarized below and as later amended or superseded:

    11.1. Emergency Care – immediately

    11.2. Emergency Dental Services – seen or treated within 24 hours

    11.3. Urgent Physical Health Services – within 72 hours

    11.4. Urgent Dental services – within 72 hours

    11.5. Well Care – within four weeks or within the community standard

    11.6. Non-Urgent Behavioral Health Treatment – within two weeks of Member request

    11.7. Routine Oral Health Care – eight weeks

12. Provider shall comply with PacificSource requests for, and in formats consistent with OHA requirements and provided by and in a frequency determined by PacificSource, practitioner information pertaining to provider directory accuracy and updated capacity and panel information.

13. Provider shall comply with OHA requirements pertaining to electronic health record adoption, and that its practitioners have access to health information exchange technology. Provider will provide to PacificSource any information about electronic health record adoption and health information exchange access, consistent with OHA requirements and obligations of PacificSource.

Attachment D

Credentialing

1. In the event that PacificSource is responsible for the credentialing of physicians and/or practitioners, the following information will be necessary to satisfy PacificSource credentialing requirements:

   1.1 Completed application for each physician and/or practitioner to include:

   (a) Physician or practitioner name

   (b) Practice name

   (c) Specialty

   (d) Physical Address

   (e) Billing Address

   (f) Tax Identification number

   (g) DEA Number

   (h) NPI number

   (i) Phone (Appointment/billing)

   (j) Fax number

   (k) Clinical privileges at primary admitting facility

   (l) Current valid license

   (m) Current valid DEA certificate (if applicable)

   (n) Education/training

   (o) Board certification (if applicable)

   (p) Current adequate professional liability coverage

   (q) History of liability claims

   (r) Work history

   1.2 Signed, dated PacificSource authorization for information release

   1.3 Signed, dated statements attesting to:

   (a) Ability to perform the essential functions of the position, with or without accommodations

   (b) Absence of present illegal drug use

   (c) Any history of loss of license and/or felony convictions

   (d) Any history of loss or limitation of privileges

   (e) The correctness/completeness of the application

   1.4 Copies of the following must accompany the application:

   (a) Current valid license

(b) Valid DEA certificate

(c) Current professional liability face sheet

2. In the event of credentialing delegation between PacificSource and Provider as specified in a separate agreement, PacificSource will require the following to satisfy PacificSource credentialing requirements:

2.1 Physician and/or practitioner demographics to include:

(a) Physician or practitioner name

(b) Practice name

(c) Specialty

(d) Physical Address

(e) Billing Address

(f) Tax Identification number

(g) DEA number

(h) NPI number

(i) Phone (Appointment/billing)

(j) Fax number

2.2 Information verification checklist for the following items. Provider is additionally required to maintain a file copy of these items:

(a) current valid DEA certificate (if applicable)

(b) current adequate malpractice insurance

(c) work history

(d) history of liability claims

2.3 Primary Source Verification, including date and initials of staff obtaining verification of the following. The information may be received in writing directly from the institution or via documented oral confirmation from the institution if that documentation includes the date received, name of the person providing the information, and the signature of the person receiving the information:

(a) Current valid license (active & good standing)

(b) Primary admitting facility (if applicable)

(c) Education/training (verification necessary only if practitioner is not board certified)

(d) Board certification (if applicable)

(e) National Practitioner Data Bank, including Medicare/Medicaid Sanctions (date queried and date received)

(f) Sanctions - Licensing Board reviewed and date of report

Attachment E

Oregon Health Plan (Oregon Health Authority) Contractual Requirements

In the event that any provision contained in this Exhibit conflicts or creates an ambiguity with a provision in this Agreement, this Exhibit's provision will prevail. The parties shall comply with all federal, state and local laws, rules, regulations and restrictions, executive orders and ordinances, the CCO Contract (defined below), OHA reporting tools/templates and all amendments thereto, and the Oregon Health Authority's ("OHA") instructions applicable to this Agreement, in the conduct of their obligations under this Agreement, including without limitation:

1. **Laws.** Provider shall comply with all applicable laws, including but not limited to the following: (i) ORS 659A.142; (ii) OHA rules pertaining to the provision of integrated and coordinated care and services, OAR Chapter 410, Division 141; (iii) all other OHA Rules in OAR Chapter 410; (iv) rules in OAR Chapter 309, Divisions 012, 014, 015, 018, 019, 022, 032, and 040, pertaining to the provisions of mental health services; (v) rules in OAR Chapter 415 pertaining to the provision of Substance Use Disorders services; (vi) state law establishing requirements for Declaration for Mental Health Treatment in ORS 127.700 through 127.737; (vii) all other applicable requirements of State civil rights and rehabilitation statutes, rules and regulations; and (viii) all applicable Medicaid laws and regulations, including sub-regulatory guidance and CCO Contract provisions. These laws, regulations, executive orders and ordinances are incorporated by reference herein to the extent that they are applicable to PacificSource Community Solutions' ("PCS") contract with OHA (the "CCO Contract") and required by law to be so incorporated. OHA's performance under the CCO Contract is conditioned upon Provider's compliance with the provisions of ORS 279B.220, 279B.230, 279B.235 and 279B.270, which are incorporated by reference herein. Provider shall, to the maximum extent economically feasible in the performance of this Agreement, use recycled paper (as defined in ORS 279A.010(1)(gg)), recycled products (as defined in ORS 279A.010(1)(hh)), and other recycled products (as "recycled product" is defined in ORS 279A.010(1)(ii)).

In compliance with the Americans with Disabilities Act, any written material that is generated and provided by Provider under this Agreement to Clients or Members, including Medicaid-Eligible Individuals, shall, at the request of such Clients or Members, be reproduced in alternate formats of communication, including without limitation Braille, large print, audiotape, oral presentation, and electronic format. PCS shall not reimburse Provider for costs incurred in complying with this provision. Provider shall cause all Subcontractors under this Agreement to comply with the requirements of this provision.

Provider shall comply with the federal laws as set forth or incorporated, or both, in the Agreement and all other federal laws applicable to Provider's performance under the Agreement as they may be adopted, amended or repealed from time to time.

This provision shall survive the termination of this Agreement for any reason.

2. **Records.** Provider agrees to comply with all applicable state and federal requirements regarding the accuracy, confidentiality, and retention of records of PCS's Members, including the requirements established by OHA, which include, but are not limited to, the retention of all records for a period of ten years from the date this Agreement expires or terminates or the completion of any litigation or OHA-related audit, whichever is later. Provider shall maintain all financial records related to this Agreement in accordance with generally accepted accounting principles or National Association of Insurance Commissioners accounting standards. This obligation includes providing access to (a) employees, as necessary and reasonable, for interviews and discussion related to such document; (b) a suitable work area and copying capabilities to facilitate such a review; and (c) Provider's premises, equipment, books,

records, contracts, computer, or other electronic systems relating to PCS's Members. In addition, this obligation includes cooperating with OHA or OHA's agent, in a timely manner, in collection of information through consumer surveys, on-site reviews, medical chart reviews, and other information for the purposes of monitoring compliance with the CCO Contract. This provision shall survive the termination of this Agreement for any reason.

3. **Right to Audit.** Provider agrees that OHA, the Center for Medicare & Medicaid Services ("CMS"), Department of Health and Human Services ("DHHS"), the Secretary of State's Office, the Office of the Inspector General, the Comptroller General of the United States, and the Oregon Department of Justice Medicaid Fraud Control Unit or their designees shall have the right to inspect, evaluate, and audit any books, documents, papers, computers or other electronic systems, contracts, and records of Provider that pertain to or are related to any aspect of the services provided under this Agreement for a period of up to ten (10) years from the date this Agreement expires or terminates, or the completion of any program-related audit, whichever is later, and such other periods in excess of ten (10) years or more as defined in OHA or Medicaid laws, rules, and regulations and CMS instructions. This provision shall survive the termination of this Agreement for any reason.

4. **Ultimate Responsibility.** Notwithstanding any term or provision of this Agreement, PCS maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its Oregon Health Plan ("OHP") contract with OHA, including without limitation all monitoring and oversight activities. Provider agrees to cooperate with PCS in meeting its responsibilities under PCS's contract with OHA and further agrees that all applicable provisions from that contract apply to Provider in the same manner in which they apply to PCS.

5. **Revocation.** In the event PCS or OHA determines that Provider has not performed satisfactorily under the terms of this Agreement or if requisite reporting and disclosure requirements are not otherwise fully met in a timely manner, PCS retains the right to terminate this Agreement in accordance with the termination provisions therein.

6. **Subcontracting Entities.** In the event Provider enters into contracts with other entities to perform its obligations hereunder, such subcontractors shall agree to comply with the terms of this Agreement, including without limitation the provisions in this Exhibit.

7. **Provider Certification.** Provider hereby certifies that all claims submissions and/or information received from Provider are true, accurate, and complete, and that payment of the claims by PCS, or its subcontractor, for OHP members will be from federal and state funds, and therefore any falsification, or concealment of material fact by Provider when submitting claims may be prosecuted under federal and state laws. Provider shall submit such claims in a timely fashion such that PCS may comply with any applicable encounter data submission timeframes, and shall include sufficient data and information for OHA to secure federal drug rebates for outpatient drugs provided to PCS's Members under this Agreement, if any. Provider hereby further certifies that it is not and will not be compensated for any work performed under this Agreement by any other source or entity.

8. **Indemnification.** Notwithstanding any indemnification provision in this Agreement, as it pertains to OHP members, Provider shall defend, save, hold harmless and indemnify the State of Oregon, its agencies and subdivisions, and their respective officers, employees, and agents from and against all claims, suits, actions, losses, damages, liabilities, costs and expenses of any nature whatsoever (including

reasonable attorneys' fees and expenses at trial, on appeal and in connection with any petition for review) resulting from, arising out of, or relating to the activities of Provider or its officers, employees, subcontractors, or agents under this Agreement.

Provider shall have control of the defense and settlement thereof, but neither Provider nor any attorney engaged by Provider, shall defend the claim in the name of the State of Oregon or any agency of the State of Oregon, nor purport to act as legal representative of the State of Oregon or any of its agencies, without the prior written consent of the Oregon Attorney General; nor shall Provider settle any claim on behalf of the State of Oregon without the approval of the Attorney General. The State of Oregon may, at its election and expense, assume its own defense and settlement in the event that the State of Oregon determines that Provider is prohibited from defending the State of Oregon, is not adequately defending its interests, an important governmental principle is at issue and the State of Oregon desires to assume its own defense.

Notwithstanding the foregoing, no party shall be liable to any other party for any incidental or consequential damages arising out of or related to services provided for the OHA contract. Provider shall ensure that the State of Oregon, Department of Human Services is not held liable for any of Provider's debts or liabilities in the event of insolvency.

9. **Insurance.** During the term of this Agreement, in addition to any requirements provided in this Agreement, Provider shall maintain and require that all persons and entities performing services under this Agreement obtain and keep in force at its own expense, each insurance noted below, as issued by a company authorized to transact business and issue insurance coverage in the State of Oregon:

(a) *Workers' Compensation.* All employers, including Provider, that employ subject workers, as defined in ORS 656.027, shall comply with ORS 656.017 and shall provide workers' compensation insurance coverage for all workers, unless they meet the requirements for an exemption under ORS 656.126(2). If Provider is a subject employer, as defined in ORS 656.023, Provider shall obtain employers' liability insurance coverage.

(b) *Professional Liability.* Covers any damages caused by an error, omission or any negligent acts related to the services to be provided under this Agreement. This insurance shall include claims of negligent Provider selection, direct corporate professional liability, wrongful denial of treatment, and breach of privacy. Provider shall provide proof of insurance with not less than the following limits:

Per occurrence limit for any single Claimant of not less than $2,000,000, and
Per occurrence limit for multiple Claimants of not less than $4,000,000.

(c) *Commercial General Liability.* Covers bodily injury, death and property damage in a form and with coverages that are satisfactory to the State. This insurance shall include personal injury liability, products and completed operations. Coverage shall be written on an occurrence basis. Provider shall provide proof of insurance with not less than the following limits:

Bodily Injury/Death -
A combined single limit per occurrence of not less than $2,000,000, and
An aggregate limit for all claims of not less than $4,000,000.

Property Damage -
A combined single limit per occurrence of not less than $200,000, and
An aggregate limit for all claims of not less than $600,000.

(d) *Automobile Liability.* Covers all owned, non-owned, or hired vehicles, this coverage may be written in combination with the Commercial General Liability Insurance (with separate limits

for "Commercial General Liability" and "Automobile Liability"). Provider shall provide proof of insurance with no less than the following limits:

Bodily Injury/Death -
A combined single limit per occurrence of not less than $2,000,000, and
An aggregate limit for all claims of not less than $4,000,000.

Property Damage -
A combined single limit per occurrence of not less than $200,000, and
An aggregate limit for all claims of not less than $600,000.

From July 1, 2016 and every year thereafter, the coverage limitations set forth herein shall be adjusted to comply with the limits determined by the State Court Administrator pursuant to ORS 30.271(4).

(e) *Additional Insured.* The Commercial General Liability insurance and Automobile Liability insurance required under this Agreement shall include PCS, the State of Oregon, its officers, employees and agents as Additional Insureds but only with respect to Provider's activities to be performed under this Agreement. Coverage shall be primary and non-contributory with any other insurance and self-insurance.

(f) *Notice of Cancellation or Change.* Provider shall assure that no cancellation, material change, potential exhaustion of aggregate limits or non–renewal of insurance coverage(s) occurs without 60 days prior written notice from Provider or its insurer(s) to PCS. Any failure to comply with this clause constitutes a material breach of this Agreement and is grounds for immediate termination of this Agreement by PCS.

(g) *Proof of Coverage.* Provider shall provide to PCS information indicating that Provider has obtained all required insurance coverage before delivering goods and performing any services required under the Agreement. Provider shall pay for all deductibles, self-insured retentions, and self-insurance, if any.

(h) *Tail Coverage.* If any of the required policies is on a "claims made" basis, then Provider shall maintain either "tail" coverage or "claims made" liability coverage, provided the effective date of the continuous "Claims made" coverage is on or before the effective date of this Agreement, for a minimum of 24 months following the later of (1) Provider's completion and PCS's acceptance of all services required under this Agreement. Notwithstanding the foregoing 24-month requirement, if Provider elects to maintain "tail" coverage and if the maximum time period "tail" coverage reasonably available in the marketplace is less than the 24-month period described above, then Provider shall maintain "tail" coverage for the maximum time period that "tail" coverage is reasonably available in the marketplace for the coverage required under this Agreement. Provider shall provide to PCS, upon PCS's request, certification of coverage required under this Section 12(h).

(i) *Self-insurance.* Provider may fulfill one or more of its insurance obligations herein through a program of self-insurance, provided that Provider's self-insurance program complies with all applicable laws, provides coverage equivalent in both type and level to that required in this Exhibit, and is reasonably acceptable to PCS. Provider shall furnish an acceptable insurance certificate to PCS for any insurance coverage required by this Agreement that is fulfilled through self-insurance. Stop-loss insurance and reinsurance coverage against catastrophic and unexpected expenses may not be self-insured

10. **Fraud Waste and Abuse.** Provider shall have in place internal controls, policies or procedures capable of preventing and detecting Fraud, Waste and Abuse activities as they relate to the OHP program; such policies and procedures to be submitted to PCS upon PCS's request. Provider shall report suspected Fraud, Waste and Abuse activities to PCS immediately upon detection and cooperate with PCS in regards to any required reporting or investigation of such activity to the Medicaid Fraud Control Unit. Provider shall comply with all patient abuse reporting requirements and fully cooperate with the State of Oregon for purposes of ORS 124.060 et seq., ORS 419B.010 et. seq., ORS 430.735 et. seq., ORS 441.630 et. seq., and all applicable Oregon Administrative Rules.

11. **Force Majeure.** Neither OHA, Provider nor PCS shall be held responsible for delay or default caused by riots, acts of God, power outage, fire, civil unrest, labor unrest, natural causes, government fiat, terrorist acts, other acts of political sabotage or war, which is beyond the reasonable control of the affected party. Each party shall, however, make all reasonable efforts to remove or eliminate such cause of delay or default and shall, upon the cessation of the cause, diligently pursue performance of its obligations under this Agreement. OHA or PCS may terminate this Agreement upon written notice to Provider after reasonably determining that the delay or default will likely prevent successful performance of this Agreement.

If the rendering of services or benefits under this Agreement is delayed or made impractical due to any of the circumstances listed in the preceding paragraph, care may be deferred until after resolution of those circumstances, except in the following situations: (a) care is needed for Emergency Services; (b) care is needed for Urgent Care Services; or (c) care is needed where there is a potential for a serious adverse medical consequence if treatment or diagnosis is delayed more than thirty (30) days.

If any of the circumstances listed in the first paragraph of this section disrupts normal execution of Provider's duties under this Agreement, Provider shall notify Members in writing of the situation and direct Members to bring serious health care needs to Provider's attention.

This provision shall survive the termination of this Agreement for any reason.

12. **Governing Law, Consent to Jurisdiction.** This Agreement shall be governed by and construed in accordance with the laws of the State of Oregon without regard to principles of conflicts of law. Any claim, action, suit or proceeding (collectively, the "claim") between OHA or any other agency or department of the State of Oregon, or both, and Provider that arises from or relates to this Agreement shall be brought and conducted solely and exclusively within the Circuit Court of Marion County, a political subdivision of the State of Oregon for the State of Oregon; provided, however, (a) if federal jurisdiction exists then OHA may remove the claim to federal court, and (b) if a claim must be brought in or removed to a federal forum, then it shall be conducted solely and exclusively within the United States District Court for the District of Oregon. In no event shall this Section be construed as a waiver of the State of Oregon of the jurisdiction of any court or of any form of defense to or immunity from any claim whether sovereign immunity, governmental immunity, immunity based on the Eleventh Amendment to the Constitution of the United States or otherwise. PROVIDER, BY EXECUTION OF THE AGREEMENT, HEREBY CONSENTS TO THE IN PERSONAM JURISDICTION OF SAID COURTS. This provision shall survive the termination of this Agreement for any reason.

13. **Independent Contractor.**

(a) Provider is not an officer, employee or agent of the State of Oregon or PCS, as those terms are used in ORS 30.265 or otherwise.

(b) If Provider is currently performing work for the State of Oregon or the federal government, Provider by signature to this Agreement, represents and warrants that Provider's work to be performed under this Agreement creates no potential or actual conflict of interest as defined by ORS Chapter 244 and that no statutes, rules or regulations of the State of Oregon or federal agency for which Provider currently performs work would prohibit Provider's work under this Agreement. If compensation under this Agreement is to be charged against federal funds, Provider certifies that it is not currently employed by the federal government.

(c) Provider is responsible for all federal and State taxes applicable to compensation paid to Provider under this Agreement and, unless Provider is subject to backup withholding, neither PCS nor OHA will withhold from such compensation any amounts to cover Provider's federal or State tax obligations. Provider is not eligible for any social security, unemployment insurance or workers' compensation benefits from compensation paid to Provider under this Agreement, except as a self-employed individual.

(d) Provider shall perform all work as an Independent Contractor. PCS reserves the right (i) to determine and modify the delivery schedule for the work and (ii) to evaluate the quality of the work product, however, OHA may not and will not control the means or manner of Provider's performance. Provider is responsible for determining the appropriate means and manner of performing the work.

(e) This provision shall survive the termination of this Agreement for any reason.

14. **Representations and Warranties.** Provider represents and warrants that:

(a) Provider has the power and authority to enter into and perform this Agreement,

(b) This Agreement, when executed and delivered, shall be a valid and binding obligation of Provider enforceable in accordance with its terms,

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

(d) Provider shall, at all times during the term of this Agreement, be qualified, professionally competent, and duly licensed to perform the work, and

(e) Provider prepared its application related to this Agreement, if any, independently from all other applicants, and without collusion, fraud, or other dishonesty.

The warranties set forth in this Section are in addition to, and not in lieu of, any other warranties provided.

15. **Assignment of Contract, Successor in Interest.** Provider shall not assign or transfer its interest in this Agreement, voluntarily or involuntarily, whether by merger, consolidation, dissolution, operation of law, or in any other manner, without prior written consent of and OHA. Any such assignment or transfer, if approved, is subject to such conditions and provisions r OHA may deem necessary, including but not limited to Exhibit B, Part 8, Sections 13 and 14 of the CCO Contract. No approval by PCS of any assignment or transfer of interest shall be deemed to create any obligation of PCS in addition to those set forth in this Agreement. The provisions of this Agreement shall be binding upon and inure to the benefit of the parties, their respective successors and permitted assigns.

16. **Survival.** In addition to any other provision of this Agreement that by its context are meant to survive termination or expiration of this Agreement, the following special terms and conditions survive

any such termination or expiration for a period of two (2) years unless a longer period is set forth in this Agreement:

(a) Submission, certification, and adjustments related to encounter data so submitted, certified, or adjusted by Provider.

(b) Financial reporting, financial reconciliations and recoupments, third party liability and recovery activities, and data related to quality and performance metrics.

(c) Maintenance of required licensing, certifications, and registrations, and responding to subpoenas, investigations and governmental inquiries.

17. **Other Provider Requirements.**

(a) Provider shall comply with the requirements of 42 CFR 438.6 where it is applicable to this Agreement.

(b) Provider shall comply with the billing and payment requirements applicable to this Agreement, including as outlined in OAR 410-141-0420 and 42 CFR §§438.106 and 438.230.

(c) Provider's information systems must meet requirements of 42 CFR 438.242 and section 1903 (r)(1)(F) of the Patient Protection and Affordable Care Act that allow PCS to utilize pertinent data for analysis of delivery system capacity, consumer satisfaction, financial solvency, encounter, utilization and quality improvement, and other reporting requirements required under the OHA contract.

(d) Provider is required to participate in internal or external quality improvement activities as instructed by PCS.

(e) Provider shall cooperate with all processes and procedures of child, elder, nursing home, developmentally disabled or mentally ill abuse reporting, investigations, and protective services.

(f) If granted access to or use of any OHA computer system or other OHA Information Asset for which OHA imposes security requirements, Provider shall comply with OAR 943-014-0300 through 943-014-0320, as such rules may be revised from time to time. For purposes of this paragraph, "Information Asset" shall have the meaning set forth in OAR 943-014-0305, as such rule may be revised from time to time.

(g) Provider agrees to subrogate to OHA any and all claims it has or may have against manufacturers, wholesale or retail suppliers, sales representatives, testing laboratories, or other providers in the design, manufacture, Marketing, pricing, or quality of drugs, pharmaceuticals, medical supplies, medical devices, DMEPOS, or other products. Provider shall notify PCS and/or OHA (Office of Payment and Recovery) when it becomes aware a Member has other coverage for the Covered Services, consistent with OAR 461-195-0301 – 461-195-0350, and will provide to OHA information Provider possesses to assist OHA in the pursuit of financial recovery. Finally, Provider shall comply with ORS 416.510 – 416.610 when enforcing an assigned lien.

(h)) Provider shall comply with all applicable requirements of State civil rights and rehabilitation statutes and rules. In addition, Provider shall not discriminate against any Member when those Members exercise their rights under OHP.

(j) To the extent applicable to Provider, Provider shall comply with OHA's required process for Grievances, Notices of Adverse Benefit Determinations, Appeals, and Contested Case Hearings, as described on the procedures document that PCS will provide Provider.

(k) Provider shall not send any marketing materials to any Member, unless such materials and the distribution thereof have been approved by PCS in accordance with the CCO Contract.

(l) Provider will be screened for exclusion from participation in federal programs and may not subcontract any services in this Agreement to a subcontractor that is an excluded entity. Further, Provider will provide reasonable cooperation to PCS such that PCS may perform a criminal background check on Provider before any work identified in this Agreement is performed.

(m) Provider shall not bill Members directly for any Non-Covered Services, unless Provider has a full written disclosure or waiver on file signed by the Member, in advance of the service being provided, in accordance with OAR 410-141-0420.

(n) To the extent applicable to Provider, Provider shall comply with timely access to care and services for Members, in accordance with OAR 410-141-3220.

(o) Provider shall also comply with all required federal terms and conditions on Attachment 1, attached hereto and incorporated herewith.

Exhibit 1

Required Federal Terms and Conditions

Unless exempt under 45 CFR Part 87 for Faith-Based Organizations (Federal Register, July 16, 2004, Volume 69, #136), or other federal provisions, and only to the extent: (i) required by law or explicitly required under the CCO Contract, and (ii) applicable to the functions delegated to Provider by this Agreement, Provider shall comply and, as indicated, cause all Subcontractors to comply with the following federal requirements to the extent that they are applicable to this Agreement, to Provider, or to the work, or to any combination of the foregoing. For purposes of this Agreement, all references to federal and State laws are references to federal and State laws as they may be amended from time to time. For purposes of this Attachment F, all capitalized terms not defined in this Agreement are as defined in the CCO Contract.

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

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

3. **Clean Air, Clean Water, EPA Regulations**. If this Agreement, including amendments, exceeds $100,000 then Provider shall comply and cause all Subcontractors to comply with all applicable standards, orders, or requirements issued under Section 306 of the Clean Air Act (42 U.S.C. 7606), the Federal Water Pollution Control Act as amended (commonly known as the Clean Water Act) (33 U.S.C. 1251 to 1387), specifically including, but not limited to Section 508 (33 U.S.C. 1368), Executive Order 11738, and Environmental Protection Agency regulations (2 CFR Part 1532), which prohibit the use under non-exempt federal contracts, grants or loans of facilities included on the EPA List of Violating Facilities. Violations shall be reported to PCS, OHA, DHHS and the appropriate Regional Office of the Environmental Protection Agency. Provider shall include and cause all Subcontractors to include in all

contracts with Subcontractors receiving more than $100,000, language requiring the Subcontractor to comply with the federal laws identified in this Section.

4. **Energy Efficiency**. Provider shall comply and cause all Subcontractors to comply with applicable mandatory standards and policies relating to energy efficiency that are contained in the Oregon energy conservation plan issued in compliance with the Energy Policy and Conservation Act, 42 U.S.C. 6201 et seq. (Pub. L. 94-163).

5. **Truth in Lobbying**. Provider certifies, to the best of Provider's knowledge and belief that:

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

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

5.3 Provider shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients and Subcontractors shall certify and disclose accordingly.

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

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

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

or officer of a State, local or tribal government in policymaking and administrative processes within the executive branch of that government.

5.7 The prohibitions in subsections 5.5 and 5.6 of this Section shall include any activity to advocate or promote any proposed, pending or future Federal, State or local tax increase, or any proposed, pending, or future requirement or restriction on any legal consumer product, including its sale or marketing, including but not limited to the advocacy or promotion of gun control.

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

6. **HIPAA Compliance**. The parties acknowledge and agree that each of OHA, PCS and Provider is a "covered entity" and Provider is a "business associate" of PCS for purposes of privacy and security provisions of the Health Insurance Portability and Accountability Act and the federal regulations implementing the Act (collectively referred to as HIPAA). OHA, PCS and Provider shall comply with HIPAA to the extent that any work or obligations of OHA or PCS arising under this Agreement are covered by HIPAA. With the assistance of PCS, Provider shall develop and implement such policies and procedures for maintaining the privacy and security of records and authorizing the use and disclosure of records required to comply with this Agreement and with HIPAA. Provider shall comply and cause all Subcontractors to comply with HIPAA and the following:

6.1 *Privacy and Security of Individually Identifiable Health Information*. Individually Identifiable Health Information about specific individuals is protected from unauthorized use or disclosure consistent with the requirements of HIPAA. Individually Identifiable Health Information relating to specific individuals may be exchanged between Provider and OHA or PCS for purposes directly related to the provision of services to Clients which are funded in whole or in part under this Agreement. However, Provider shall not use or disclose any Individually Identifiable Health Information about specific individuals in a manner that would violate HIPAA Privacy Rules in 45 CFR Parts 160 and 164, OHA Privacy Rules, OAR Chapter 407 Division 014, or OHA Notice of Privacy Practices, if done by OHA or PCS. A copy of the most recent OHA Notice of Privacy Practices is posted on the OHA web site at: https://apps.state.or.us/cf1/Forms/, Form number ME 2090 Notice of Privacy Practices, or may be obtained from OHA.

6.2 *HIPAA Information Security*. Provider shall adopt and employ reasonable administrative and physical safeguards consistent with the Security Rules in 45 CFR Part 164 to ensure that Member Information shall be used by or disclosed only to the extent necessary for the permitted use or disclosure and consistent with applicable State and federal laws and the terms and conditions of this Agreement. Security incidents involving Member Information must be immediately reported to DHS' Privacy Officer.

6.3 *Data Transactions Systems*. Provider shall comply with the HIPAA standards for electronic transactions published in 45 CFR Part 162 and the DHS EDT Rules, OAR 410-001-0000 through 410-001-0200. In order for Provider to exchange electronic data transactions with OHA in connection with Claims or encounter data, eligibility or Enrollment information,

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

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

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

8. **Audits.** Provider shall comply and require all Subcontractors to comply, with the applicable audit requirements and responsibilities set forth in this Agreement and applicable state or federal law. If Provider expends $750,000 or more in Federal funds (from all sources) in a federal fiscal year, Provider shall have a single organization-wide audit conducted in accordance with the provisions of 2 CFR Subtitle B with guidance at 2 CFR Part 200. Copies of all audits must be submitted to PCS and OHA within thirty (30) days of completion. If Provider expends less than $750,000 in a federal fiscal year, Provider is exempt from Federal audit requirements for that year. Records must be available as provided in Exhibit B, "Records Maintenance, Access" of the CCO Contract.

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

9.1 Provider is controlled by a sanctioned individual;

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

9.3 Provider employs or contracts, directly or indirectly, for the furnishing of health care, utilization review, medical social work, or administrative services, with one of the following:

9.3.1 Any individual or entity excluded from participation in Federal health care programs.

9.3.2 Any entity that would provide those services through an excluded individual or entity.

9.3.3 Provider is prohibited from knowingly having a person with ownership of 5% or more of the Provider's equity who is (or is affiliated with a person/entity that is) debarred, suspended, or excluded from participation in federal healthcare programs.

10. **Pro-Children Act**. Provider shall comply and cause all Subcontractors to comply with the Pro-Children Act of 1994 (codified at 20 U.S.C. Section 6081 et. seq.).

11. **Additional Medicaid and CHIP**. Provider shall comply with all applicable federal and State laws and regulations pertaining to the provision of OHP Services under the Medicaid Act, Title XIX, 42 U.S.C. Section 1396 et. seq., and CHIP benefits established by Title XXI of the Social Security Act, including without limitation:

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

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

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

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

13. **Clinical Laboratory Improvements**. Provider shall and shall ensure that any Laboratories used by Provider shall comply with the Clinical Laboratory Improvement Amendments (CLIA 1988), 42 CFR Part 493 Laboratory Requirements and ORS 438 (Clinical Laboratories, which require that all laboratory testing sites providing services under this Agreement shall have either a Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number. Those Laboratories with certificates of waiver will provide only the eight types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.

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

14.1 Their rights under Oregon law.

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

14.3 Provider must inform Members that complaints concerning noncompliance with the Advance Directive requirements may be filed with OHA.

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

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

16. **Risk HMO**. If Provider is a Risk HMO and is sanctioned by CMS under 42 CFR 438.730, payments provided for under this Agreement will be denied for Members who enroll after the imposition of the sanction, as set forth under 42 CFR 438.726.

17. **Conflict of Interest Safeguards**.

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

17.2 Provider shall not offer, give, or promise to offer or give to any DHS or OHA employee (or any relative or member of their household), and such employees shall not accept, demand, solicit, or receive any gift or gifts with an aggregate value in excess of $50 during a calendar year or any gift of payment of expenses for entertainment. "Gift" for this purpose has the meaning defined in ORS 244.020(6) and OAR 199-005-0001 to 199-005-0035.

17.3 Prior to the award of any replacement contract, Provider shall not solicit or obtain, from any DHS or OHA employee, and no DHS or OHA employee may disclose, any proprietary or

source selection information regarding such procurement, except as expressly authorized by the Director of OHA or DHS.

17.4 Provider shall not retain a former DHS or OHA employee to make any communication with or appearance before OHA on behalf of Provider in connection with this Agreement if that person participated personally and substantially in the procurement or administration of this Agreement as a DHS or OHA employee.

17.5 If a former DHS or OHA employee authorized or had a significant role in this Agreement, Provider shall not hire such a person in a position having a direct, beneficial, financial interest in this Agreement during the two year period following that person's termination from DHS or OHA.

17.6 Provider shall develop appropriate policies and procedures to avoid actual or potential conflict of interest involving Members, DHS or OHA employees, and sub-contractors. These policies and procedures shall include safeguards:

17.6.1 against Provider's disclosure of applications, bids, proposal information, or source selection information; and

17.6.2 requiring Provider to:

(a) promptly report any contact with an applicant, bidder or offeror in writing to OHA; and

(b) reject the possibility of possible employment; or disqualify itself from further personal and substantial participation in the procurement if Provider contacts or is contacted by a person who is an applicant, bidder or offeror in a procurement involving federal funds regarding possible employment for Provider.

17.7 The provisions of this Section on Conflict of Interest are intended to be construed to assure the integrity of the procurement and administration of this Agreement. For purposes of this Section:

17.7.1 "Agreement" includes any similar contract between Provider and PCS or OHA for a previous term.

17.7.2 Provider shall apply the definitions in the State Public Ethics Law, ORS 244.020, for "actual conflict of interest", "potential conflict of interest", "relative" and "member of household".

17.7.3 "Provider" for purposes of this Section includes all Provider's affiliates, assignees, subsidiaries, parent companies, successors and transferees, and persons under common control with Provider; any officers, directors, partners, agents and employees of such person; and all others acting or claiming to act on their behalf or in concert with them.

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

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

18. **Non-Discrimination**. Provider shall comply, and require its Subcontractors to comply, with all federal and State laws and regulations including Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972 (regarding education programs and activities) the Age Discrimination Act of 1975, the Rehabilitation Act of 1973, the Americans with Disabilities Act (ADA) of 1990, and all amendments to those acts and all regulations promulgated thereunder.

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

20. **Patient Rights Condition of Participation**. To the extent applicable, Provider shall comply with, and shall require Subcontractors to comply with, the Patient Rights Condition of Participation ("COP") that hospitals must meet to continue participation in the Medicaid program, pursuant to 42 CFR Part 482. For purposes of this Agreement, hospitals include short-term, psychiatric, rehabilitation, long-term, and children's hospitals.

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

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

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

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

21.3 Part 84 (nondiscrimination on the basis of handicap);

21.4 Part 91 (nondiscrimination on the basis of age);

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

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

22. **Mental Health Parity**. Provider shall adhere to CMS guidelines regarding Mental Health Parity detailed below:

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

22.2 If Provider includes an aggregate lifetime or annual dollar limit on at least two-thirds of all medical/surgical benefits provided to enrollees, it must either apply the aggregate lifetime or

annual dollar limit both to the medical/surgical benefits to which the limit would otherwise apply and to mental health or substance use disorder benefits in a manner that does not distinguish between the medical/surgical benefits and mental health or substance use disorder benefits; or not include an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is more restrictive than the aggregate lifetime or annual dollar limit, respectively, on medical/surgical benefits;

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

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

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

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

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

22.8 Provider may not impose non-quantitative treatment limitations ("NQTLs") for mental health or substance use disorder benefits in any classification unless, under the policies and procedure of the Provider as written and in operation, any processes, strategies, evidentiary standard, or other factors used in applying the NQTL to mental health or substance use disorder benefits in the classification are comparable to and are applied no more stringently than, the process, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits in the classification;

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

22.10 Provider shall use processes, strategies, evidentiary stands or other factors in determining access to out of network providers for mental health or substance use disorder benefits that are comparable to an applied no more stringently than, the processes, strategies, evidentiary standards or other factors in determining access to out of network providers for medical/surgical benefits in the same classification.