Oregon
Theodore R. Kulongoski, Governor

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DHS

2003-04 OREGON HEALTH PLAN

MENTAL HEALTH ORGANIZATION AGREEMENT

MULTNOMAH COUNTY (Verity)

#106-906

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2003-2004 OREGON HEALTH PLAN
Mental Health Organization Agreement

PART I
Contractor Data, Approvals and Signatures

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

Department of County Human Services,
Multnomah County

hereinafter referred to as Contractor. DHS's supervising representative for this Agreement is the OMHAS Community Services Section (CSS) Manager.

I. Organization of Agreement

This Agreement consists of Part I and Part II, Oregon Administrative Rules (OARs) cited herein, and Exhibits A through L, which are attached hereto and incorporated herein by this reference. The definitions that apply to this Agreement are set forth in Exhibit K.

II. Status of Contractor

A. Type of Business:

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

Contractor is not a Health Care Services Contractor as defined in ORS 750.005 (2).

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

B. Service Area

Contractor's designated Service Area is Multnomah County. Contractor shall serve, under the terms and conditions set forth in this Agreement, Oregon Health Plan (OHP) Clients living in this County who are enrolled with Contractor by DHS as described in Part II, Section IV, Enrollment and Disenrollment, of this Agreement.

C. Status of Contractor

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

D. Corporate Activity

Multnomah County agrees to include all of the Multnomah Verity Integrated Behavioral Healthcare Systems' business activities under Corporate Activity when completing Reports C1 through C5. Any changes to the reporting of Corporate Activity shall be approved by OMHAS in writing before implementation.

III. Contractor Information

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

The individual signing this Agreement on behalf of Contractor hereby certifies and swears, under penalty of perjury: (a) that the number shown below is the correct Contractor taxpayer identification number, and that Contractor is not subject to backup withholding because: (i) Contractor is exempt from backup withholding, (ii) Contractor has not been notified by the IRS that Contractor is subject to backup withholding as a result of failure to report all interest or dividends, or (iii) the IRS

has notified Contractor that Contractor is no longer subject to backup withholding; (b) that s/he is authorized to act on behalf of Contractor, has authority and knowledge regarding Contractor's payment of taxes, and to the best of her/his knowledge, Contractor is not in violation of any Oregon tax laws (including, without limitation, those listed below); (c) that Contractor is an independent contractor as defined in ORS 670.600; and (d) that the information set forth in this Part I, Section IV. Contractor Information, is true and accurate. For purposes of this certificate, "Oregon tax laws" means the state inheritance tax, gift tax, personal income tax, withholding tax, corporation income and excise taxes, amusement device tax, timber taxes, cigarette tax, other tobacco tax, 9-1-1 emergency communications tax, the homeowners and renters property tax relief program and local taxes administered by the Department of Revenue (Multnomah County Business Income Tax, Lane Transit District Tax, Tri-Metropolitan District Employer Payroll Tax, and Tri-Metropolitan Transit District Self-Employment Tax).

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

assumes financial responsibility for defective workmanship or for services not provided as evidenced by the ownership of performance bonds, warranties, errors and omission insurance or liability insurance relating to the labor or services to be provided.

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

Contract Number: 106-906

Contract Period: October 1, 2003 through September 30, 2004

LEGAL BUSINESS NAME: Multnomah County
(This must match the name in which your TIN was issued)

Address: 421 SW 6th Street, 7th Floor
City, State, Zip: Portland, Oregon 97204-1618
Telephone: (503) 988-3691
Facsimile Number: (503) 988-3379

TAXPAYER IDENTIFICATION NUMBER: 93-6002309
(Federal Employer Identification Number)

STATE TAX IDENTIFICATION NUMBER: Same as above

Business Designation

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

IV. Signatures

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

Contractor:
Multnomah County

Diane Linn, Chairperson Date
Board of County Commissioners

John Ball, Interim Director Date
Department of County Human Services

Thomas Sponsler Date
Multnomah County Counsel

DHS, Office of Mental Health and Addiction Services:

Authorized Signature Date
Madeline Olson, Asst. Administrator
Office of Mental Health and Addiction Services

Approved as to Legal Sufficiency:

Assistant Attorney General Date

Reviewed:

DHS Contracts Coordinator Date

PART II

STATEMENT OF WORK, TERMS AND CONDITIONS

I. Term and Approval

This Agreement shall become effective October 1, 2003 or on the date at which both parties have signed this Agreement and this Agreement has been approved for legal sufficiency by the Oregon Department of Justice, whichever is later, and shall continue in effect, unless otherwise terminated or extended, through September 30, 2004. No work may be performed under this Agreement prior to its effective date.

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

II. Interpretation and Administration of Agreement

A. DHS may adopt reasonable and lawful policies, procedures, rules and interpretations to promote orderly and efficient administration of this Agreement. In interpreting this Agreement, its terms and conditions shall be construed as much as possible to be complementary, giving preference to Parts I and II of the Agreement over any exhibits or attachments. In the event that DHS needs to look outside of this Agreement, exhibits, and attachments for purposes of interpreting its terms, DHS shall consider the following sources in the order listed:

1. The Grant Award Letters from the Centers for Medicare and Medicaid Services (CMS) for operation of the Oregon Reform

Demonstration (Oregon Health Plan (OHP) Medicaid Demonstration Project), including all special terms and conditions and waivers.

2. The Federal Medicaid Act, Title XIX of the Social Security Act, and its implementing regulations except as waived by CMS for the OHP Medicaid Demonstration Project and the State Children's Health Insurance Program (SCHIP), Title XXI of the Social Security Act, as amended and administered in Oregon by DHS.

3. The Oregon Revised Statutes concerning the OHP.

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

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

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

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

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

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

1. Administrative Review

Contractor shall send the request for administrative review to OMHAS Supervising Representative with a postmark within 30 calendar days of the effective date or announcement date,

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

2. Contested Case Hearings

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

Contractor shall send the request for a contested case hearing to OMHAS Supervising Representative, or designee, with a postmark not later than 30 calendar days following the date of notice of adverse decision resulting from the administrative review process. Contested case hearings shall follow the process described in OAR 410-120-1720, Provider Appeals – Hearing Evidence, through OAR 410-120-1840, Provider Hearings-Role of the Hearing Officer, except that such hearings shall be heard by the Hearings Officer Panel or other independent hearings officer designated by DHS.

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

III. Administrative Rules and Applicable Law

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

Contractor shall comply with OAR 410-120-1380, which establishes the requirements for compliance with Section 4751 of Omnibus Budget Reconciliation Act (OBRA) 1991 and ORS 127.649, Patient Self-Determination Act. Contractor shall use Oregon Department of Consumer and Business Services approved forms to record compliance with this requirement.

IV. Enrollment and Disenrollment

A. Enrollment

1. Enrollment is the process by which DHS signs on with a particular contractor those individuals who have been determined to be eligible for Services under the OHP Medicaid Demonstration Project and State Children's Health Insurance Program. DHS shall sign on such individuals with contractor selected by the individual. If an eligible individual does not select a contractor, DHS may, pursuant to OAR 410-141-0060, Oregon Health Plan Managed Care Enrollment Requirements, elect to assign the person to a contractor selected by DHS. DHS has no obligation to enroll with Contractor any individual who has not selected a contractor. Contractor shall have an open Enrollment period at all times, during which Contractor shall accept, without restriction, all eligible individuals in the order in which they apply and are signed on with Contractor by DHS, unless Contractor is also a Fully Capitated Health Plan (FCHP) and DHS and Contractor have jointly closed Enrollment because Contractor maximum

Enrollment limit has been reached or for any other reason mutually agreed to by DHS and Contractor under the FCHP Agreement.

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

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

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

4. DHS shall make available to Contractor Enrollment data files via an electronic bulletin board . Enrollment data files appearing on the bulletin board shall remain there until deleted and replaced with the most recent Enrollment data files resulting from the weekly or monthly Enrollment cutoff and compilations process. For the weekly Enrollment process, an Enrollment data file of new and disenrolled OHP Members shall appear on the electronic bulletin board Thursday morning of each week. For the monthly Enrollment process, Enrollment data files of new, closed and ongoing OHP Members for the next month shall appear on the electronic bulletin board three working days following the date of monthly Enrollment cutoff. An Enrollment listing shall be made available to Contractor by the 5th of the month in which the Enrollments are applicable.

B. Disenrollment

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

2. An OHP Member may be disenrolled from Contractor in accordance with OAR 410-141-0080, Oregon Health Plan Disenrollment from Prepaid Health Plans. Contractor or the Psychiatric Security Review Board (PSRB) may request Disenrollment of an OHP Member under the jurisdiction of PSRB. OMHAS approval is required for Disenrollment requests of Contractor or PSRB for OHP Members under PSRB jurisdiction.

3. The effective date of Disenrollment shall be the date determined in accordance with OAR 410-141-0080, Oregon Health Plan Disenrollment from Prepaid Health Plans. For OHP Members under PSRB jurisdiction who are approved for Disenrollment at the request of Contractor or PSRB, the effective date of Disenrollment may be made retroactive to the date the OHP Member was enrolled with Contractor or placed under PSRB jurisdiction, whichever is more recent.

4. If DHS disenrolls an OHP Member retroactively, any Capitation Payments received by Contractor for that OHP Member after the effective date of Disenrollment shall be handled as described in Part II, Section VII, Consideration, Subsection E, Settlement of Accounts.

V. Statement of Work

The Oregon Health Plan (OHP) has been restructured with the passage of House Bill 2519 which authorized application to the Center for Medicare and Medicaid Services (CMS) to amend and expand the current demonstration project under Section 1115 of the Social Security Act. The restructured OHP program in its entirety is referred to as "OHP2". OHP2 has three components, OHP Plus, OHP Standard and Family Health Insurance Assistance Program.

A. Benefit Package

Contractor shall provide Covered Services to OHP Members consistent with OAR 410-141-0120, Oregon Health Plan Prepaid Health Plan Provision of Health Care Services; OAR 410-141-0520, Prioritized List of Health Services; and OAR 410-141-0480, Oregon Health Plan Benefit Package of Covered Services.

1. Flexible Services

When delivering a Flexible Service (as opposed to using a Flexible Service Approach) and the Provider rendering a Flexible Service is not licensed or certified by a state board or licensing agency, or employs personnel to provide the Service who do not meet the definition for Qualified Mental Health Associate (QMHA) or Qualified Mental Health Professional (QMHP) as described in Exhibit K, Definitions, Provider must meet criteria described in Part II, Section V, Statement of Work, Subsection N, Item 1.a.(2) Credentialing process.

2. Provision of Covered Services

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

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

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

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

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

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

e. Contractor shall pay for Covered Services needed to assess an Emergency Situation. If Contractor has a reasonable basis to believe that Covered Services claimed to be Emergency Services were not in fact Emergency Services, Contractor may deny payment for such Services. Such Services shall not be considered Covered Services. In such circumstances, Contractor shall, within 45 calendar days of receipt of a claim for payment, notify:

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

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

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

g. Contractor may not prohibit or otherwise limit or restrict a mental health care professional (acting within the scope of practice) from advising or advocating on behalf of an OHP Member for:

(1.) their mental health care status, medical care or treatment options, regardless of whether Contractor provides benefits for the particular type of care or treatment;

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

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

(4.) the OHP Member's rights to participate in decisions regarding mental health care, including the right to refuse treatment, and to express preferences about treatment decisions.

h. Contractor shall provide for a second opinion regarding diagnosis and prescribed treatment from a qualified mental health care professional within the Provider Panel, or arrange for the ability of the OHP Member to obtain one outside the Provider Panel, at no cost to the OHP Member.

3. Mental Health Services Which are Not Covered Services

Contractor shall assist its OHP Members in gaining access to certain mental health Services that are not Covered Services and that are provided under separate contract with DHS. Services that

are not Covered Services include, but are not limited to, the following:

a. Medical Transportation;

b. Medication;

c. Psychiatric Day Treatment for OHP Members under 21 years of age (except for those Services included in the Intensive Treatment Services Pilot Project);

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

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

f. Secure Children's Inpatient program (SCIP) services for OHP members age 14 and under;

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

h. Psychiatric Residential Treatment Services (PRTS) for OHP Members under 21 years of age (except for those Services included in the Intensive Treatment Services Pilot Project);

i. Child and Adolescent Treatment Program (CATP) at the Oregon State Hospital (OSH) (except for those Services included in the Intensive Treatment Services Pilot Project):

j. Investigation of OHP Members for civil commitment;

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

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

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

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

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

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

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

r. Personal Care Services as described in OAR 411-34-000 through 411-34-090 and OAR 309-040-0000 through 309-040-0100.

4. Client Notices

Each time a Service or benefit will be terminated, suspended or reduced, or a request for Service authorization or request for claim payment is denied, Contractor shall issue a Notice of Action. Contractor is not obligated to issue a Notice of Action under one or more of the conditions described in Exhibit G, Oregon Health Plan Mental Health Services Client Notices, Complaint and Hearings Process. Contractor shall make available in all clinics, Participating Provider offices, and other Service locations

frequented by OHP Members, information concerning client notices, Complaints and hearings.

5. Practice Guidelines

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

6. Utilization Management

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

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

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

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

e. If Contractor adopts Treatment Parameters or Utilization Guidelines, Contractor shall establish an appeal process that allows for an independent clinical review of the decision by one or more QMHPs who were not involved in the original Utilization Management decision. Contractor may use its Complaint process for resolving utilization management appeals.

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

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

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

7. Authorization for Services

a. Contractor shall have procedures in place for the consistent application of review criteria for authorization decisions; and that any decision to deny the amount, duration, or scope of a Service request be made by a health care professional who has the appropriate clinical expertise in treating the OHP Member's mental health condition.

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

c. Contractor shall make a decision regarding a request for Service authorization and notify the OHP Member and Provider within fourteen (14) calendar days following receipt of the request, with a possible extension of 14 additional calendar days if the OHP Member or Provider requests extension, or the Contractor requires additional information. If Contractor extends the time frame, Contractor shall give the OHP Member a written notice of the reason for the decision to extend the timeframe and inform the OHP Member of the right to file a grievance if he or she disagrees with that decision. When a decision is not reached regarding a Service authorization request within the timeframes specified above, Contractor shall issue a Notice of Action to the Provider and OHP Member, or OHP Member Representative, consistent with Exhibit G, Oregon Health Plan Mental Health Services Clients Notices, Grievances, Appeals and Hearings Process.

d. If an OHP Member or Provider requests an expedited authorization decision, Contractor shall make a decision and notify the OHP Member and Provider within 72 hours after receipt of the Service authorization request.

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

B. Delivery System Configuration

1. Needs Assessment

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

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

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

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

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

c. Contractor shall coordinate its needs assessment and Service delivery system planning effort with organized planning

efforts carried out by the Local Mental Health Authorities of its Service Area.

2. Components of the Delivery System

a. Services Coordination

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

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

b. Preventive and Early Intervention Services

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

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

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

(c) Contractor shall have Services that are appropriate to the age, gender, socioeconomic

status, ethnicity, clinical history, and risk characteristics of its OHP Membership.

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

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

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

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

c. Rehabilitative Treatment Services

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

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

d. 24 Hour Urgent and Emergency Response System

(1) Contractor shall provide covered mental health Emergency Services that are needed immediately, or appear to be needed immediately by a prudent

layperson, because of a sudden mental health condition. Contractor is obligated to pay all necessary mental health Emergency Services which are medically Appropriate, until the emergency is stabilized, including those of non-participating mental health practitioners or licensed facilities. Contractor may not deny payment for covered mental health Emergency Services obtained when a representative of the Contractor, or its Providers, instructs the OHP Member to seek Emergency Services.

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

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

e. Involuntary Psychiatric Care

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

(2) Contractor shall have written policies and procedures describing the Appropriate use of Emergency Psychiatric Holds and alternatives to Involuntary Psychiatric Care when a less restrictive voluntary Service will not meet the Medically Appropriate needs of the OHP Member and the behavior of the OHP Member meets legal standards for the use of an Emergency Psychiatric Hold.

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

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

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

f. Acute Inpatient Hospital Psychiatric Care

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

V. Statement of Work, Subsection N, Credentialing Process, Item 1.b. and c.

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

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

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

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

h. Intensive Treatment Services Pilot Program

(1) The Intensive Treatment Services Pilot Program is a range of service components in a system of care inclusive of Psychiatric Residential Treatment Services, Psychiatric Day Treatment Services, Psychiatric Residential Assessment and Evaluation Services and services at the Child and Adolescent Treatment Program (CATP) unit at the Oregon State Hospital.

(2) Contractor shall provide Psychiatric Residential Treatment Services, as well as other services as determined by Contractor, to provide active psychiatric treatment for children and adolescents with severe mental or emotional disorders whose needs cannot be adequately addressed in traditional settings. Contractor shall provide Medically Appropriate services in the least restrictive setting at a level consistent with the continued stay criteria for the services that were included in the Intensive Treatment Services Pilot Project Request for Information dated February 11, 1999, which is incorporated herein by this reference.

(3) The maximum number of children to be served under this Agreement for the ITS Pilot Program shall be:

50 (fifty) children

(4) Contractor shall notify OMHAS monthly of its OHP Members that are identified to participate in the ITS Pilot Program.

a) DHS will send Contractor a pre-printed Turnaround Document (TAD) each month with the names of the OHP Members participating in the ITS Pilot Program;

b) Contractor will review the TAD, make the necessary changes, and forward the TAD to OMHAS within three (3) working days of receipt of the document. Delay of the return of the TAD will cause delay of the monthly payment to Contractor;

c) OMHAS will verify the OHP member's eligibility and enrollment with Contractor, as well as check to ensure that duplicate payments are not being made for the OHP Member to the ITS provider through any other contracts with DHS;

d) Once all information on the TAD is verified, OMHAS will notify the DHS Community Accounting Office to issue the monthly payment to Contractor .

(5) An ITS payment will be made monthly to Contractor on the 15th day of each month, or the next working day if the payment day falls on a weekend or holiday. The payment will be the daily case rate identified in Section V.,B., h., (6) times the days in which qualified participating OHP Members are in the ITS Pilot Program. The maximum payment will be the maximum number of children for which payment is received times the actual days in any given month. OMHAS will make adjustments to the monthly payment in the event that there are days for which the number of qualified participating OHP Members is fewer than the maximum number specified in Section V.B.2. g.(3).

(6) The ITS Pilot Program rate methodology is based on a blended case rate model. The model calculates the number of dedicated slots times the weighted average daily slot cost for the specific providers participating, times the budgeted days per year to get a Budgeted Service Cost. An additional 7.25% administrative cost is added to establish a Total Fund Cost. The total number of dedicated slots is then divided in the Total Fund Cost to establish a blended case rate. The Yearly Blended Case Rate is divided by 365 (days per year) to establish a daily case rate:

$230.75 per day per qualified participating enrollee

(7) Contractor shall work closely with OMHAS to ensure continuous enrollment for children entering into the ITS Pilot Program who are placed in treatment facilities outside Contractor's Service Area, as defined in Part I, Section III.B. Contractor shall notify OMHAS when an enrollee is admitted to an ITS Pilot Program, as well as when the enrollee is scheduled for discharge from the program. OMHAS will work with allied agencies to make the system adjustments that are necessary to accomplish continuous enrollment with Contractor. Eligibility determinations will not be affected and will continue to be subject to the DHS cirteria for participation in the OHP.

(8) SSI disability payments are considered a primary payer resource for children who qualify for and received Supplement Security Income (SSI) disability payments and are enrolled in Psychiatric Residential or Psychiatric Residential Assessment and Evaluation treatment programs, or other out-of-home placement, for longer than thirty (30) days where Contractor has payment responsibility for room and board in addition to clinical services. Under federal rules and guidelines, if a beneficiary is receiving care in a federal, state, or private facility because of mental or physical incapacity, a portion of the SSI disability

payment is to be used for the beneficiary's costs incurred for room and board to offset other federal resources. Therefore, the monthly payment to Contractor for these children will be reduced, as required by federal law, by an amount determined by DHS . Contractor, or their subcontracted providers, will be responsible for recovery of the portion of the SSI disability payment from the parents and guardians of the child to apply to the cost of the program. Contractors will notify OMHAS when an ITS child who receives SSI payments is placed in a treatment setting outside the home for more than thirty (30) days, at which time Contractor's monthly payment for that child will be reduced. Contractor will notify OMHAS when the child is returned to the home to reinstate the full payment of the monthly rate.

(9) Contractor will not restrict services for children in the ITS Pilot Program, but will provide all Medically Appropriate services covered in the MHO Agreement for mental health services in the OHP benefit package including flexible services that Contractor may develop for children with this level of need.

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

(11) Contractor shall have policies and procedures in place to assure timely reimbursement to participating providers in the ITS Pilot Program.

(12) Contractor shall have written policies and procedures describing the admission and discharge criteria for a child requiring ITS Pilot Program level of care. Process shall include the active participation of the family, allied agencies, and other persons involved in

the child's care. Process shall be consistent with that described in Contractor's response to the Intensive Treatment Services Pilot Project Request for Information dated February 11, 1999.

(13) Contractor shall be required to submit additional reports and information as identified by OMHAS for the purposes of research and evaluation of the ITS Pilot Program. OMHAS will continue to contract with a professional review organization for an independent review to collect clinical information for children served through the ITS Pilot Program.

(14) OMHAS reserves the right to terminate the ITS Pilot Program services identified in the MHO Agreement by mutual consent of both parties or by either party upon thirty (30) calendar days written notice.

3. Integration and Coordination

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

a. Mental Health Services Which Are Not Covered Services

Contractor shall coordinate Services for each OHP Member who requires Services from agencies providing mental health Services that are not Covered Services. These Services include, but are not limited to, those listed in Section V. Statement of Work, Subsection A, Benefit Package, item 3, Mental Health Services Which Are Not Covered Services.

(1) Contractor shall assist OHP Members who are children and adolescents in gaining access to intensive treatment services, such as Psychiatric Residential

Treatment Services, Psychiatric Residential Assessment and Evaluation Services, Psychiatric Day Treatment Services, the Secure Children's Inpatient Program (SCIP), or services at the Child and Adolescent Treatment Program (CATP) unit at the Oregon State Hospital, when these levels of care are Medically Appropriate.

(a) Contractor shall work closely with OMHAS staff to ensure continuous enrollment for OHP Members entering into intensive treatment services outside of Contractor's Service Area, as defined in Part I, Section III.B.

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

(c) Contractor shall coordinate, consult, and communicate, within laws governing confidentiality, with community providers and other allied agencies, schools, family members or guardians regarding treatment for children and adolescents in intensive treatment services.

b. Local Mental Health Authority (LMHA)/Community Mental Health Program (CMHP)

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

c. Community Emergency Service Agencies

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

d. Local and/or Regional Allied Agencies

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

e. Physical Health Care Providers

Contractor shall coordinate with physical health care Providers and Fully Capitated Health Plans as follows:

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

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

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

f. Chemical Dependency Providers

Contractor shall coordinate with Chemical Dependency Providers as Medically Appropriate and within laws governing confidentiality and shall provide technical assistance for the identification and referral of OHP Members with dual diagnoses. Contractor shall work with FCHPs and Chemical Dependency Providers certified by DHS to develop the Capacity to provide Appropriate Services to dually diagnosed OHP Members so the needs of such persons can be better met.

g. Medicare Payers and Providers

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

h. OHP Members in Extended Care Settings

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

i. Long Term Psychiatric Care (LTPC)

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

DHS staff shall render a determination within three working days of receiving a completed request if the OHP Member is 18 or more years of age or within seven working days of receiving a completed request if the OHP Member is under age 18.

(a) For OHP Members age 18 to age 64 with no significant nursing care needs due to an Axis III disorder of an enduring nature, the OMHAS Extended Care Management Unit (ECMU) as described in Exhibit H.1., Procedure for Long Term Psychiatric Care Determinations for OHP Members Age 18-64;

(b) For OHP Members age 14 and under, the OMHAS SCIP Representative, and for OHP Members age 15 through 18, the Oregon State Hospital, Child and Adolescent Treatment Program (CATP), Community Outreach Team (COT) Representative as described in Exhibit H.2., Procedure for Long Term Psychiatric Care Determinations for OHP Members Under Age 18; and

(c) For OHP Members age 65 and over or age 18 to age 64 with significant nursing care needs due to an Axis III disorder of an enduring nature, the Oregon State Hospital Geropsychiatric Treatment Service (OSH-GTS), Outreach and Consultation Service (OCS) Team as described in Exhibit H.3, Procedure for Long Term Psychiatric Care Determinations for Persons Requiring Geropsychiatric Treatment.

(2) An OHP Member is Appropriate for LTPC when the OHP Member needs either Intensive Psychiatric Rehabilitation or other Tertiary Treatment in a State Hospital or Extended Care Program, or Extended and Specialized Medication Adjustment in a secure or otherwise highly supervised environment; and the

OHP Member has received all Usual and Customary Treatment, including, if Medically Appropriate, establishment of a Medication Management Program and use of a Medication Override Procedure.

(3) DHS shall cover, the cost of LTPC of OHP Members determined Appropriate for such care beginning on the effective date specified below in Section V.B.3.i.(3) and ending on the date the OHP Member is discharged from such setting

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

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

(b) No more than seven (7) calendar days following the date the OMHAS SCIP Representative or the OSH COT Representative receives a completed Long Term Psychiatric Care Determination for Persons Under Age 18 form; or

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

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

(e) In cases where the Clinical Reviewer determines a date other than a date described above in Section V.B.3.i.(3)(a) through V.B.3.i.(c), the date determined by the Clinical Reviewer.

(4) In the event there is a disagreement between Contractor and OMHAS about whether an OHP Member is Appropriate for LTPC, Contractor may request, within three (3) working days of receiving notice of the LTPC determination, review by an independent Clinical Reviewer. The determination of the Clinical Reviewer shall be deemed the determination of OMHAS for purposes of this Agreement. If the Clinical Reviewer ultimately determines that the OHP Member is Appropriate for LTPC, the effective date of such determination shall be the date specified above in Section V.B.3.i.(3). The cost of the clinical review shall be divided equally between Contractor and OMHAS . The Clinical Reviewer established for the period of this Agreement shall be the Oregon Medical Professional Review Organization (OMPRO) or such other similar person or organization mutually established by DHS and Contractor.

(5) Contractor shall work with the OMHAS ECMU, OMHAS SCIP Representative, the OSH COT Representative or OCS Team in managing admissions to and discharges from LTPC for OHP Members who require such care at Oregon State Hospital or Eastern Oregon Psychiatric Center.

(a) Contractor shall also work with the OHP Member and, for OHP Members under age 18, or over age 18 with legal guardians, the parent or guardian of the OHP Member to assure timely discharge from LTPC to an Appropriate community placement.

(b) Contractor shall also work with the OSH-GTS Interdisciplinary Treatment Team assigned to the OHP Member in managing discharges from Long Term Geropsychiatric Care.

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

j. Consumer Involvement and Advocacy

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

2. Contractors' advisory bodies, such as Quality Improvement committees, policy-making bodies or decision-making boards, shall have representation from culturally diverse populations of mental health consumers and their family members. Representation on these advisory bodies shall be a minimum of 25% of total membership and shall consist of representatives which include the following constituent groups: adolescent consumers, adult consumers, older adult consumers, family members of child and adolescent consumers and family members of adult and older adult consumers.

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

C. Delivery System Capacity

1. Contractor shall maintain a Provider Panel with adequate Capacity and expertise to provide timely and Appropriate access to Covered Services across the age span from child to older adult.

a. Contractor shall monitor Capacity and adjust Capacity as needs change over time.

b. Contractor shall consider geographic location of Providers and OHP Members when monitoring Capacity in outlying portions of its Service Area under this Agreement and for OHP Members who cannot reasonably be served in a clinic setting.

c. Contractor shall provide OHP Members with a choice of Providers within Contractor's Provider Panel consistent with Section 1932(a)(1)(2)(3) of Title XIX of the Social Security Act and Section (1)(b) of OAR 410-141-0120, Oregon Health Plan Prepaid Health Plan Provision of Health Care Services; Section (2)(c) of OAR 410-141-0320, Oregon Health Plan Prepaid Health Plan Member Rights and Responsibilities; and Section (1)(a) of OAR 410-141-0160, Oregon Health Plan Prepaid Health Plan Continuity of Care.

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

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

3. If Contractor is unable to provide necessary Covered Services which are Medically Appropriate to a particular OHP Member within its Provider Panel, Contractor shall adequately and timely cover these services out of network for the OHP Member, for as long as Contractor is unable to provide them. Out of network providers must coordinate with Contractor with respect to payment.

D. Accessibility and Continuity of Care

1. Contractor shall comply with OAR 410-141-0220, Oregon Health Plan Prepaid Health Plan Accessibility and OAR 410-141-0160, Oregon Health Plan Prepaid Health Plan Continuity of Care.

2. In addition to access and Continuity of Care standards specified in the rules cited above in Subsection D.1., Contractors shall establish

standards for access to Covered Services and Continuity of Care which, at a minimum, include the following:

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

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

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

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

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

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

g. For routine travel time from the OHP Member residence to the Participating Provider, Contractor shall assure that OHP

Members spend no more time traveling than the Community Standard.

3. Contractor shall have effective methods for monitoring compliance with standards D.2.a. through D.2.g. above and shall have efficient strategies for taking prompt corrective action when compliance falls below those standards.

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

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

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

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

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

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

OHP Member and/or OHP Member Representative has been advised of the Complaint and DHS Hearings processes.

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

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

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

1. QA/QI System

a. Contractor and its Subcontractors shall have a planned, systematic and ongoing process for monitoring, evaluating and improving the access, quality, and Appropriateness of Covered Services provided to OHP Members. The process shall include written policies, standards, and procedures that address the needs of OHP Members. Contractor shall have in effect, mechanisms to detect both underutilization and overutilization of services. If Contractor delegates any QA/QI activity, the process must state the extent of the delegation and how these activities are integrated in the overall QA/QI system.

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

c. Stakeholder Input

Contractor shall have a formal and ongoing process for gathering and considering information from Stakeholders including, but not limited to: OHP Members, consumers,

consumer advocates, Families, parent advocates, family members of older adults, Local and/or Regional Allied Agencies, child psychiatrists, geropsychiatrists, child advocates, and Health Care Professionals.

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

2. Quality Improvement Work Plan

Contractor shall develop and submit to OMHAS a written Quality Improvement Work Plan within 45 days of the effective date of this Agreement. OMHAS shall review the Quality Improvement Work Plan and notify Contractor of its determination within 30 days of receipt.

a. Contractor shall develop performance improvement projects that measure performance using Measurable Objectives and measurable quality indicators, implement system interventions to achieve improvement in quality, evaluate the effectiveness of the interventions, and includes a plan for increasing or sustaining improvement in the following domains: Access to Services; Quality of Services; Integration and Coordination of Services; Prevention, Education, and Outreach; and Outcomes.

b. Contractor shall work with OMHAS to identify at least three activities to measure compliance with the applicable terms and requirements of this Agreement.

c. Contractor shall submit a Quality Improvement Work Plan report to OMHAS describing progress toward objectives and benchmarks 45 days after the termination of this Agreement.

3. Measurable Objectives and Benchmarks

Contractor shall develop and monitor progress toward Measurable Objectives and Benchmarks in the above mentioned domains.

Contractor shall demonstrate that findings are used to improve access and remove barriers to Covered Services; improve Capacity to provide Covered Services in a timely manner; improve the Quality of Care provided and the coordination of benefits, and strengthen and expand Prevention, Early Intervention and Education Services.

4. Member of OMHAS QA Committee

Contractor shall participate, if such participation is requested by OMHAS , as a member of the QA Committee of OMHAS.

F. Informational Materials and Education of OHP Members

1. Contractor shall develop or provide informational materials and educational programs as described in OAR 410-141-0280, Oregon Health Plan Prepaid Health Plan Information Requirements and OAR 410-141-0300, Oregon Health Plan Prepaid Health Plan Member Education. These materials and programs shall be tailored to the backgrounds and special needs of OHP Members. Contractor shall develop, and make available to its OHP Members, a mental health education program that addresses Prevention and Early Intervention of mental illness. Contractor shall offer OHP Member orientation that includes information on Contractor's Grievance and Complaint process.

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

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

b. Make oral interpretation Services available and inform OHP Members how to access those services;

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

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

3. Contractor shall make the following information available to OHP Members upon request:

a. With respect to mental health Providers, information that includes, but is not limited to, education, licensure, Board certification and recertification;

b. Information on requirements for accessing Services, including information on physical accessibility and non-English languages spoken;

c. Description of the procedures Contractor uses to control utilization of Services and expenditures;

d. A summary description of the methods of compensation for Providers; and

e. Information on the financial condition of Contractor, including the most recently audited information.

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

5. Contractor shall have written policies and procedures that meet the requirements for advance directives with respect to adult OHP Members receiving mental health services, as set forth in 42 CFR 489.102. Contractor shall provide written information to adult OHP Members on advance directive policies within 14 calendar days of OHP Member's effective date of coverage with Contractor.

G. OHP Member Rights

1. Contractor shall develop, by the effective date of this Agreement, written policies and procedures incorporating and ensuring the rights and responsibilities of OHP Members consistent with ORS 430.210, Rights of Service Recipients; Status of Rights; OAR 410-141-0320, Oregon Health Plan Prepaid Health Plan Member Rights and Responsibilities; ORS 430.735 through 430.765, Abuse Reporting for the Mentally Ill; and OAR 309-040-0200 through 309-040-0290, Abuse Reporting and Protective Services in Community Programs and Community Facilities.

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

   a. The right to receive Covered Services;

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

   c. The right to be actively involved in the development of Treatment Plans if Covered Services are to be provided and to have parents involved in such Treatment Planning consistent with OAR 309-032-0950 through 309-032-1080, Standards for Community Treatment Services for Children;

   d. The right to consent to Treatment and refuse Covered Services;

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

   f. The right to request and receive a copy of his or her own Clinical Record, (unless access is restricted in accordance with ORS 179.505 or other applicable law) and to request

that the records be amended or corrected as specified in 45 CFR part 164;

g. The right to have Clinical Records kept confidential consistent with laws listed in OAR 410-141-0180, Oregon Health Plan Prepaid Health Plan Recordkeeping and ORS 179.505 through 179.507;

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

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

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

k. The right to receive a Notice of Action when a Service, benefit, Request for Service Authorization or Request for Claim Payment is denied; or prior to termination, suspension or reduction of a benefit or
Service as described in Exhibit G, Oregon Health Plan Mental Health Services Client Notices, Complaint and Hearings Process;

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

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

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

o. The right to receive, within 30 calendar days of Enrollment, written materials describing at least the following topics: rights and responsibilities, benefits available, how to access Covered Services, what to do in an Emergency Situation, and how to make a Complaint;

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

q. The right to access protective Services as described in ORS 430.735 through 430.765, Abuse Reporting for Mentally Ill and OAR 309-040-0200 through 309-040-0290, Abuse Reporting and Protective Services in Community Programs and Community Facilities;

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

s. The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other Federal regulations on the use of restraints and seclusion.

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

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

H. Grievances and Appeals

1. Contractor shall have a Grievance system which includes a Grievance process, an Appeal process and access to the administrative hearings process, consistent with Exhibit G, Oregon Health Plan Mental Health Services Client Notices, Grievances, Appeals and Hearings Process. Contractor shall provide all Providers and Subcontractors information regarding the

Contractor's Grievance, Appeal and Hearings Process at the start of each contract and shall include the following information:

a. The OHP Member's right to file grievances and appeals and the procedures and timeframes for filing;
b. The OHP Member's right to a DHS administrative hearing, how to obtain a hearing, and representation rules at a hearing;
c. How the OHP Member can receive assistance in filing a grievance, an appeal, or administrative hearing request;
d. The toll-free numbers for OHP Members to file oral grievances and appeals;
e. The OHP Member's right to request continuation of benefits during an appeal or administrative hearing filing and, if the Contractor's action is upheld in a hearing, the OHP Member may be liable for the cost of any continued benefits; and
f. Provider appeal rights to challenge payment or authorization decisions made by Contractor.

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

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

4. Contractor shall give OHP Members any reasonable assistance in completing forms and other procedural steps, not limited to

providing interpreter services and toll-free numbers with TTY/TDD and interpreter capability.

I. Financial Risk, Management and Solvency

Contractor shall assume the risk for providing Covered Services to its OHP Members. Contractor shall maintain sound financial management consistent with OAR 410-141-0340, Oregon Health Plan Prepaid Health Plan Financial Solvency and shall maintain protections against Insolvency, as specified in Exhibit C, Solvency Plan and Financial Reporting. If Contractor expects to change any elements of the Solvency Plan or solvency protection arrangements, Contractor shall provide written advance notice to OMHAS at least sixty (60) calendar days before the proposed effective date of change. Such changes are subject to written approval from the OMHAS Community Services Section Manager.

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

b. In the event that insolvency occurs, Contractor remains financially responsible for providing Covered Services for OHP Members through the end of the period for which Contractor has been paid.

c. Contractor shall not bill, charge, seek compensation, remuneration, or reimbursement from any OHP Member for any debt or payment of claims due to Contractor's insolvency.

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

J. Recordkeeping

1. Clinical Records

Contractor shall maintain recordkeeping consistent with OAR 410-141-0180, Oregon Health Plan Prepaid Health Plan

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

2. Financial Records

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

3. Government Access to Records

Contractor shall provide, CMS, the Comptroller General of the United States, the Oregon Secretary of State, DHS and all their duly authorized representatives the right of access to facilities and to financial (including all accompanying billing records), clinical, and personnel records and other books, documents, papers, plans and writings of Contractor, ot its Subcontractors, that are pertinent to this Agreement to perform examinations and audits and make

excerpts and transcripts. Contractor shall retain and keep accessible all financial and personnel records and books, documents, papers, plans, and writings for a minimum of three (3) years, or such longer period as may be required by applicable law, following final payment and termination of this Agreement, or until the conclusion of any audit, controversy or litigation arising out of or related to the Agreement, whichever date is later. Contractor shall, upon request and without charge, provide a suitable work area and copying capabilities to facilitate such a review or audit.

K. Reports

1. Participating Provider Listing and Capacity Report

Contractor shall submit to OMHAS, one calendar month following the effective date of this Agreement, the Mental Health Services Practitioner Report, as described in Exhibit A.

2. Complaint Log

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

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

3. QA Reports

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

4. Financial and Utilization Reports

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

5. Practitioner Incentive Plans

   Contractor shall submit to OMHAS information necessary to comply with Sections 4204 (a) and 4731 of OBRA of 1990 that concern Practitioner Incentive Plans, if applicable. Such information shall be provided using reports specified in Exhibit I, Practitioner Incentive Plans.

6. Abuse Reporting and Protective Services

   For adult OHP Members, Contractor and Participating Providers shall comply with all protective Services, investigation and reporting requirements described in OAR 309-040-0200 through 309-040-0290, Abuse Reporting and Protective Services in Community Programs and Community Facilities and ORS 430.735 through 430.765, Abuse Reporting for Mentally Ill.

7. Key Personnel

   Contractor shall submit to OMHAS, within 30 days following the effective date of this Agreement, and immediately following any changes, the names and contact numbers for the following key personnel: Contract Liaison, Quality Assurance/Improvement Liaison, Complaint and Hearing Liaison, and Long Term Psychiatric Care Liaison.

L. Data Systems

1. Encounter Data

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

a) verifying the accuracy and timeliness of reporting data;

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

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

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

2. Client Process Monitoring System

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

3. Oregon Patient/Resident Care System

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

4. Failure to Comply with Data Submission Requirements

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

5. Other Systems

Contractor shall have automated capacity adequate to track changes to and errors in the Enrollment listing; track Utilization Management activities; coordinate benefits with other payers; collect funds from other payers; and track claims received, adjudicated and paid.

M. Research, Evaluation and Monitoring

1. In addition to submission of data described in Part II, Section V, Statement of Work, Subsection L, Data Systems, Contractor shall cooperate with OMHAS in collection of information through Consumer surveys, on-site reviews, medical chart reviews, financial reporting and financial record reviews, interviews with staff, and other information for the purposes of monitoring compliance with this Agreement and for developing and monitoring performance objectives. Contractor shall assist OMHAS with development and distribution of survey instruments for use in evaluating integration of Covered Services in the OHP Medicaid Demonstration Project and State Children's Health Insurance Program. Contractor and its Subcontractors shall provide access to records and facilities as described in OAR 410-141-0180, Oregon Health Plan Prepaid Health Plan Recordkeeping, Part II, Section V, Statement of Work, Subsection J, Recordkeeping and Section XXX, Agreement Compliance and Quality Assurance Monitoring.

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

3. Contractor, or its Subcontractors, shall cooperate with DHS by providing access to records and facilities for the purpose of an annual external, independent professional review of the quality outcomes and timeliness of, and access to, Services provided under

this Agreement. If the professional review organization identifies an adverse clinical situation in which follow-up is needed to determine whether Appropriate care was provided, Contractor shall assign a staff person(s) to follow-up with the Provider, inform Contractor's QI Committee of the finding, and involve the QI Committee in the development of the resolution.

N. Credentialing Process

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

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

      (1) Participating Providers must meet the definitions for QMHA or QMHP as described in Exhibit K, Definitions and provide Services under the supervision of a Licensed Medical Practitioner (LMP) as defined in Exhibit K, Definitions; or

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

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

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

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

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

3. Contractor's Subcontractors and Participating Providers shall work within the scope of registration or licensure and qualifications

specified in Part II, Section V, Statement of Work, Subsection N, Credentialing Process, Items 1.a. through 1.c.

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

5. As described in OAR 410-141-0280 (2) (e), Contractor shall provide written notice to affected OHP Members of any significant changes in program or Service sites that impacts the OHP Members' ability to access care or Services from Contractor's Providers. Such notice will be provided to OMHAS and the OHP Members at least thirty (30) days prior to the effective date of that change, or as soon as possible if the Provider has not given Contractor sufficient notification to meet the 30 days notice requirement.

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

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

8. Contractor is not required to contract with providers beyond what is necessary to meet the needs of its OHP Members. Contractor's provider selection policies and procedures shall not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. If Contractor declines to include individuals or groups of providers in its network, Contractor must give the affected provider(s) written notice of the reason for its decision.

O. Delegation of Activities

Contractor is responsible for the Quality of Care and Services provided under the terms and requirements of this Agreement. Subject to the provisions of this section, Contractor may subcontract any or all of the work to be performed under this Agreement. No subcontract shall terminate or limit Contractor's legal responsibility to DHS for the timely and effective performance of its duties and responsibilities under this Agreement.

1. Before any delegation of activities, Contractor shall evaluate the prospective Subcontractor's ability to perform the activities to be delegated.

2. Contractor shall have a written agreement that specifies the delegated activities and reporting responsibilities of the Subcontractor.

3. The following requirements of this Agreement may not be delegated:

    a. Oversight and Monitoring of QA/QI Activities;
    b. Adjudication of Final Appeals in a Member Complaint and Grievance Process; and

4. Contractor's agreement with the Subcontractor shall provide for the revocation of the delegation or imposition of other sanctions if the Subcontractor's performance is inadequate to meet the requirements of this Agreement.

5. Contractor shall monitor the Subcontractor's performance on an ongoing basis and perform a review at least once a year.

6. All subcontracts shall meet the requirements described below and shall incorporate portions of this Agreement, as applicable, based on the scope of work to be subcontracted.

    a. Must be in writing and incorporate each applicable requirement of this Agreement, including the following: Part II, Section V, Statement of Work, Subsection J,

Recordkeeping; Section XXIII, Indemnification; Section XXV, Professional Liability Insurance; Section XXVI, Tort Claims; Section XXVIII, Workers' Compensation Coverage; Section XXIX, Additional Federal Requirements; Section XXXI, Amendments and Terminations; and every other provision in this Agreement that sets requirements for any of the activities being subcontracted.

b. Clearly identify work to be performed by the Subcontractor and what portion of that work, if any, the Subcontractor may further subcontract.

c. Ensure that the requirements of 42 CFR Part 434 that are appropriate to the Services or activity required under the subcontract are fulfilled.

d. Contain a provision that the Subcontractor shall not bill, charge, seek compensation, remuneration or reimbursement from, or have recourse against DHS or any OHP Member for Covered Services provided during the period for which Capitation Payments were made by DHS to Contractor with respect to said OHP Member, even if Contractor becomes insolvent.

e. Contain a provision that the Subcontractor shall continue to provide Covered Services during periods of Contractor Insolvency or cessation of operations through the period for which Capitation Payments were made to Contractor.

f. Contain a provision requiring the Subcontractor to follow OAR 410-141-0420, Billing and Payment Under the Oregon Health Plan, when submitting Fee-For-Service claims for Oregon Health Plan Services provided to OHP Members that are not Covered Services.

g. In cases where the Subcontractor has assumed any risk covered under this Agreement, contain a provision that the Subcontractor must protect itself against loss by either self-insuring or providing proof of Reinsurance and by

maintaining a Restricted Reserve Fund as described in Exhibit C, Solvency Plan and Financial Reporting.

h. If Contractor chooses to delegate the Complaints and Grievance Process, Contractor shall require the Subcontractor to have written policies and procedures for accepting, processing and responding to all Complaints and Grievances from Family Members, Local and/or Regional Allied Agencies, and OHP Members consistent with Exhibit G, Oregon Health Plan Mental Health Services Client Notices, Complaint and Hearings Process.

i. Contain a provision that data used for analysis of delivery system Capacity, Consumer satisfaction, financial solvency, and Encounter, client process monitoring, and Acute Inpatient Hospital Psychiatric Care admission data submission must be provided to Contractor to meet reporting requirements described in Exhibit A, Mental Health Services Practitioner Report; Exhibit B, Health Plan Complaint Log; Exhibit C, Solvency Plan and Financial Reporting; Exhibit D, Encounter Minimum Data Set Requirements; Exhibit E, Client Process Monitoring System; and Exhibit F, Oregon Patient/Resident Care System.

j. Contain a provision that requires the Subcontractor to have a planned, systematic and ongoing process for monitoring, evaluating and improving the quality and Appropriateness of Covered Services provided to OHP Members.

k. Contain a provision that requires the Subcontractor to participate in QA and QI activities of Contractor, or those of OMHAS if requested to do so.

l. Contain a provision that requires the Subcontractor to provide access to records and facilities as described in OAR 410-141-0180, Oregon Health Plan Prepaid Health Plan Recordkeeping, Part II, Section V, Statement of Work, Subsection J, Recordkeeping and Section XXX, Agreement Compliance and Quality Assurance Monitoring and to

cooperate with OMHAS in medical and financial record reviews, and Agreement compliance and QA monitoring.

m. Contain a provision that requires the Subcontractor to cooperate with all processes and procedures of Abuse reporting, investigations, and protective Services as described in ORS 430.735 through 430.765, Abuse Reporting for Mentally Ill and OAR 309-040-0200 through 309-040-0290, Abuse Reporting and Protective Services in Community Programs and Community Facilities.

7. On the effective date of this Agreement, Contractor shall notify OMHAS in writing of activities to be delegated and the entities performing such delegated activities. Contractor shall provide a list which shall include the delegated entity's business name, address, phone number, name of executive director and activities to be performed. Contractor shall notify OMHAS in writing of changes to the list within thirty (30) calendar days of such change.

P. Participation of Suspended or Terminated Providers

The Covered Services provided by Contractor under this Agreement may not be rendered by individuals or entities who are currently excluded from Medicaid participation under section 1128 or section 1128A of the Social Security Act. Contractor shall not refer OHP Members to such Providers and shall not accept billings for Services to OHP Members submitted by such Providers.

Q. Health Insurance Portability and Accountability Act (HIPAA)

1. Contractor is a "covered entity" for the purposes of the provisions of the Health Insurance Portability and Accountability Act (HIPAA), Title II, Subtitle F, Administrative Simplification, or the federal regulations implementing the Act. Contractor shall develop and implement such policies and procedures for maintaining the privacy and security of records and authorizing the use and disclosure of records consistent with HIPAA and/or other federal, state, and local laws, rules and regulations applicable to the work performed under this Agreement.

2. Contractor, its agents, employees, Providers and Subcontractors shall ensure that confidential records are secure from unauthorized disclosure. Electronic storage and transmission of confidential OHP Member information and records shall assure accuracy, backup for retention, and safeguards against tampering, back dating, or alteration.

3. Guidelines to ensure the security of the electronic transmission of OHP Member confidential information shall be developed by DHS. Within the available resources, and consistent with DHS's testing schedule, Contractor shall initiate a request to DHS for testing and review of security measures.

4. Contractor shall comply with HIPAA standards for electronic transactions published in 65 Fed. Reg. 50312 (August 17, 2000) and consistent with the Administrative Simplification Compliance Act (extending the deadline for compliance with transaction and code set requirements until October 12, 2003, subject to submission of a compliance plan to DHHS). Contractor shall initiate a request to DHS for the testing of systems and the implementation of such policies and procedures as may be required to comply with HIPAA standards.

VI. Revision of Covered Services

Consistent with state law, Covered Services may be expanded, limited or otherwise changed by the Health Services Commission (HSC), or by the Legislative Assembly. Contractor shall provide Covered Services consistent with the expansion or limitation, subject to Contractor's right to terminate this Agreement as provided for in Part II, Section XXXI, Amendments and Termination. DHS shall promptly notify Contractor by certified mail of changes to Covered Services.

VII. Consideration

A. Payment Types and Rates

In consideration of all work to be performed by Contractor under this Agreement, DHS shall pay Contractor a monthly Capitation Payment for each OHP Member, for the period beginning on the date of Enrollment

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

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

2. DHS has developed actuarially set Adjusted Per Capita Costs necessary to cover the reasonable costs of the services to be provided under this Agreement. A full description of the methodology used to calculate per capita costs may be found in the PriceWaterhouseCoopers (PWC) document *Analysis of Federal Fiscal Years 2002-2003: Average Costs,* dated September 21, 2000. A full description of the methodology used to calculate Capitation Payments may be found in the PWC document *Oregon Health Plan Medicaid Demonstration Capitation Rate Development, Federal Fiscal Year 2002,* dated September 19, 2002. The general methodology and description of the actuarial basis for calculating Capitation Payments is described in Exhibit L, Capitation Rates with Administrative Fees.

3. DHS shall provide, upon Contractor request, and when available, documents produced by the actuarial firm which document and describe the Capitation rate development process.

B. Payment In Full

The consideration listed in Exhibit L, plus any reimbursement for pilot programs outlined in this Agreement, is the total consideration payable to Contractor for all work performed under this Agreement.

C. Changes in Payment Rates

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

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

2. In the event of any action as described in Part II, Section VII, Consideration, Section C, Changes in Payment Rates, Item 1., DHS shall prepare and provide to Contractor an amendment to this Agreement. The new Capitation Payment under such amendment shall take effect no earlier than thirty (30) calendar days from the date the amendment is mailed or delivered to Contractor and, no earlier than sixty (60) calendar days following final legislative action.

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

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

D. Timing of Capitation Payments

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

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

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

E. Settlement of Accounts

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

DHS shall have no obligation to make any payments to Contractor for any period(s) during which Contractor substantially fails to carry out the

terms of this Agreement. Any payments received by Contractor from DHS for such periods, and any other payments received by Contractor from DHS to which Contractor is not entitled under the terms of this Agreement, shall be considered an overpayment and shall be recovered from Contractor.

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

F. Remedies Short of Termination

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

VIII. Marketing

Contractor shall ensure that staff activities and written materials do not intentionally mislead potential OHP Members about options available through Contractor. Contractor shall cooperate with OMHAS in developing written materials to be included in OHP Medicaid Demonstration Project and State Children's Health Insurance Program application packets.

1. Contractor, and Subcontractors, shall not initiate contact nor market independently to potential OHP Members in an attempt to influence an individual's enrollment with Contractor, without the express written consent of OMHAS.

2. Contractor and Subcontractors may not conduct, directly or indirectly, door-to-door, telephonic, mail or other cold call marketing practices to entice OHP Members to enroll with Contractor, or to not enroll with another Contractor.

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

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

5. Contractor shall submit to OMHAS, for review and approval, all written marketing materials to OHP Members that reference benefits and/or coverage. Marketing materials expressly for the purpose of mental health promotion, education or outreach do not require prior approval.

IX. Identification Cards

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

X. Third Party Resources

A. Notice to Health Insurance Group

Contractor shall notify the Health Insurance Group, Third Party Recovery Unit, Adult and Family Services within thirty (30) calendar days from the time that Contractor learns that an OHP Member might have other health insurance. This notification shall be provided on a Provider Insurance Response Form (AFS 8708) and shall include the OHP Member's name, Social Security number, State Medicaid number, name of the policyholder, the name and address of the insurance company, group and/or policy number, and any other identifying information available to Contractor, such as dates of coverage.

B Secondary Payer Status and Retroactive Disenrollment

Contractor is secondary payer when the OHP Member is covered by another health insurance policy. Contractor shall notify DHS Health Management Unit (HMU) within thirty (30) calendar days from the time that Contractor learns that an OHP Member might have other insurance. If DHS determines that the OHP Member has sufficient Third Party Resources, DHS may disenroll the OHP Member in accordance with OAR 410-141-0080, Oregon Health Plan Disenrollment from Prepaid Health Plans. The effective date of Disenrollment shall be the first of the month after DHS makes such a determination unless DHS specified a retroactive effective date of Disenrollment pursuant to OAR 410-141-0080(3), except that such date shall not exceed 18 months. When an OHP Member is retroactively disenrolled, DHS shall recoup all Capitation Payments from the date of Disenrollment.

C. Collection of Third Party Resources

Contractor is required to make a reasonable effort to secure payment from Third Party Resources (TPR). To the extent permitted by law, Contractor shall make a reasonable effort to identify and pursue such TPR without regard to any Capitation Payments received by Contractor under this Agreement. Contractor shall have a system for obtaining timely assignment of the rights to recovery or the assignment of lien rights from the OHP Member and /or Provider as necessary to effectively

pursue TPR claims. If Contractor is unable to gain cooperation from the OHP Member in pursuing TPR, Contractor shall notify the DHS Third Party Recovery Unit of the OHP Member's refusal to cooperate.

D. Confidentiality

When pursuing TPR, Contractor shall follow federal and state guidelines relating to confidentiality pursuant to Part II, Section XXII, including without limitation, the federal (42 CF Part 2) and state (ORS 426.460 and ORS 179.505) confidentiality laws and regulations governing the identity and medical/client records of OHP Members. DHS considers Contractor's sending of claims and supporting documentation to a third party insurer to facilitate third party recovery a purpose directly connected with the administration of the Medicaid program. To the extent authorized by law, the DHS Third Party Recovery Unit shall share client and claim information received with Contractor to assist Contractor in third party recovery.

E. Claims Processing

Contractor may not refuse payment on Valid Claims based solely on Contractor's belief that there may be potential TPR, absent documentation of potential TPR. If a Provider cannot obtain recovery from the TPR, Contractor shall not delay payment to the Provider.

F. Accounting for Third Party Collections

Contractor shall be responsible for maintaining records in such a manner so as to ensure that all monies collected from TPR on behalf of OHP Members may be identified and reported to OMHAS in accordance with Exhibit C, Solvency Plan and Financial Reporting. Contractor shall also keep records of third party recovery efforts that are not successful. Contractor shall make these records available for audit and review consistent with the provisions of this Agreement.

G. Third Party Recoveries

Contractor shall pursue third party recovery during this Agreement period pursuant to the requirements of this Agreement, federal and state laws, rules and regulations. The Capitation rate(s) in this Agreement are

based, in part, on projected third party recoveries. Contractor's failure to submit third party recovery data and/or pursue recoverable third party recovery obligations during this Agreement may create a claim for reimbursement to the extent required by federal law.

H. Dual Coverage

If Contractor also provides commercial insurance, Contractor shall have a systematic process for identifying OHP Members with dual or overlapping coverage with Contractor and shall notify DHS within fifteen (15) working days of the time such an OHP Member is identified. Contractor shall reimburse DHS, within thirty (30) working days of receipt of monthly billing from DHS for Capitation Payments made on behalf of OHP Members with dual coverage. Contractor is not required to notify DHS on the effective date of Medicare HMO coverage for a dual eligible OHP Member.

I. Indian Health Service and Tribal Facilities

Pursuant to 42 CFR 36.61, subpart G, Indian Health Service and Tribal Facilities are the payer of last resort and are not considered an alternative resource or Third Party Resource.

XI. Merger

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

XII. Ownership

Contractor shall notify OMHAS of any changes in the ownership of Contractor and provide OMHAS with full and complete information of each person or corporation with an ownership or contractor interest (which equals or exceeds 5

percent) in the managed care plan, or any Subcontractor in which Contractor has an ownership interest that equals or exceeds 5 percent.

XIII. Funds Available and Authorized

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

XIV. Dual Payment

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

XV. Government Status

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

XVI. Successors in Interest

Contractor shall not assign or transfer any of its interest in this Agreement without the prior written consent of OMHAS. Subject to the immediately

preceding sentence, the provisions of this Agreement shall be binding upon and shall inure to the benefit of the parties hereto, and their respective successors and permitted assigns, if any. In addition to any other assignment or transfer of interest, for purposes of this Agreement, all of the following fundamental changes shall be considered an assignment of an interest in this Agreement subject to OMHAS prior written consent.

A. A consolidation or merger of Contractor, or of a corporation or other entity or person controlling or controlled by Contractor, with or into a corporation or entity or person, or any other reorganization or transaction or series of related transactions involving the transfer of more than 50% of the equity interest in Contractor or more than 50% of the equity interest in a corporation or other entity or person controlling or controlled by Contractor, or

B. The sale, conveyance or disposition of all or substantially all of the assets of Contractor, or of a corporation or other entity or person controlling or controlled by Contractor, in a transaction or series of related transactions.

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

XVII. Force Majeure

Neither Contractor nor DHS shall be held responsible for delay or default caused by fire, riot, war, major disaster, epidemic, or acts of God which is beyond either Contractor's or DHS's reasonable control. Contractor or DHS shall, however, make all reasonable efforts to remove or eliminate such a cause of delay or default and shall, upon cessation of the cause, diligently pursue performance obligations under this Agreement.

If the rendering of Services or benefits under this Agreement is delayed or made impractical due to a labor dispute involving Contractor, care may be deferred until after resolution of the labor dispute except when care or Service is needed for an emergency or Urgent need or when there is a potential for a serious adverse mental health or medical consequence if Treatment or Diagnosis is delayed more than thirty (30) calendar days.

If a labor dispute disrupts normal execution of Contractor duties under this Agreement, Contractor shall notify OHP Members in writing of the situation and direct OHP Members to bring serious health care needs to Contractor's attention.

XVIII. Headings and Captions

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

XIX. Controlling State Law/Venue

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

XX. Severability

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

XXI. Waiver

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

XXII. Non-Discrimination

Contractor shall comply with Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972 (regarding education programs and activities) the Age Discrimination Act of 1975, the Rehabilitation Act of 1973, the Americans with Disabilities Act (ADA) of 1990, and all amendments to those acts and all regulations promulgated thereunder. Contractor shall also comply with all applicable requirements of state civil rights and rehabilitation statutes and rules.

XXIII. Indemnification

Contractor shall defend, save, hold harmless and indemnify the State of Oregon, DHS and their officers, agents, employees, from and against all claims suits, actions, damages, liabilities, costs and expenses of whatsoever nature resulting from, arising out of, or relating to the activities or omissions of Contractor or its officers, employees, agents or Subcontractors under this Agreement. If Contractor is a county (as the word "county" is used in Article XI, Section 10 of the Oregon Constitution) and a public body (as "public body" is defined in ORS 30.260(4)), Contractor's liability under this Agreement is subject to the limitations of the Oregon Tort Claims Act and of Article XI, Section 10 of the Oregon Constitution.

To the extent permitted by Article XI, Section 7 of the Oregon Constitution and by the Oregon Tort Claims Act, DHS shall indemnify, within the limits of the Oregon Tort Claims Act, Contractor against liability for damage to life and property arising from DHS activities under this Agreement, provided DHS shall not be required to indemnify Contractor for any such liability arising out of the wrongful acts of Contractor or the employees, agents, or Subcontractors of Contractor.

XXIV. Public Contractor's Liability

If Contractor is a county (as the word "county" is used in Article XI, Section 10 of the Oregon Constitution), notwithstanding any other provisions of this Agreement, including without limitations the following sections of Part II: Section IV, Enrollment and Disenrollment and Section VII, Consideration, Subsection E, Settlement of Accounts and Subsection G, Remedies Short of Termination, of this Agreement, Contractor's liability under this Agreement is subject to the limitations of Article XI, Section 10 of the Oregon

Constitution. However, Contractor shall exercise its best efforts in maintaining adequate reserves (including, if necessary, reserves in excess of the amount specified in Exhibit C, Solvency Plan and Financial Reporting), obtaining appropriate loss and liability insurance and seeking any necessary funding or spending authorization so as to prevent its responsibilities under this Agreement from becoming a debt or a pledge of credit in violation of the provisions of Article XI, Section 10 of the Oregon Constitution. In the event that Contractor anticipates or determines that its responsibilities under this Agreement might or will violate Article XI, Section 10 of the Oregon Constitution, Contractor shall immediately notify DHS, and DHS may, in its sole discretion, terminate this Agreement upon notice to Contractor or at some later date specified in the notice.

XXV. Professional Liability Insurance

Contractor shall ensure that all persons and entities performing Services under this Agreement obtain and keep in effect during the term of this Agreement professional liability insurance which provides coverage of direct and vicarious liability relating to any damages caused by an error, omission or any negligent acts. Except to the extent that the Oregon Tort Claims Act, ORS 30.260 or 30.300, is applicable and imposes lesser limitations, Contractor shall ensure professional liability insurance coverage of not less than the amount of $1,000,000 per person per incident and not less than $1,000,000 in the aggregate either through a binder issued by an insurance carrier or by Contractor's self-insurance with proof of same to be provided to OMHAS upon request.

XXVI. Tort Claims

Contractor and its Subcontractors, employees, and agents are performing the work under this Agreement as independent Contractors and not as officers, employees, or agents of the State as those terms are used in ORS 30.265. It is understood, however, that if Contractor subcontracts with an Oregon public entity, officer or employee, that entity, officer or employee will be an independent Contractor but may be subject to the Oregon Tort Claims Act, ORS 30.260 to 30.300.

XXVII. Compliance with State Laws

DHS's performance hereunder is conditioned upon Contractor's compliance with provisions of ORS 279.312, 279.314, 279.316, 279.320. In accordance with ORS 279.555 (1)(e) and (f), Contractor shall, to the maximum extent economically feasible in the performance of this Agreement, use recycled paper (as defined in ORS 279.545(4)), recycled PETE products (as defined in ORS 279.545(5)), as well as other recyccled plastic resin products (as "recycled product" is defined in ORS 279.545(6).

XXVIII. Workers' Compensation Coverage

All employers, including Contractor, that employ workers who work under this Agreement in the State of Oregon shall comply with ORS 656.017 and provide the required Workers' Compensation coverage, unless such employers are exempt under ORS 656.126. Contractor shall ensure that each of its Subcontractors complies with these requirements.

XXIX. Additional Federal Requirements

Contractor shall comply with Subsections A-K, and shall include the provisions of Subsections A-D and F-G of this Section in all subcontracts and Subsection E when subcontracting with a clinical laboratory as if Subcontractor is Contractor.

A. Contractor certifies, to the best of Contractor's knowledge and belief, that:

1. No federally appropriated funds have been paid or will be paid, by or behalf of Contractor, to any person for influencing or attempting to influence 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.

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, Contractor agrees to complete and submit Standard Form-LLL "Disclosure Form to Report Lobbying", in accordance with its instructions.

3. Contractor shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

4. Contractor is solely responsible for all liability arising from a failure by Contractor to comply with the terms of this certification. Additionally, Contractor promises to indemnify DHS for any damages suffered by DHS as a result of Contractor's failure to comply with the terms of this certification.

5. This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S. 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.

B. If the sums payable to Contractor under this Agreement exceed $100,000, Contractor shall comply with all applicable standards, orders or requirements issued under Clean Air Act (codified at 42 USC 7401 et. seq.), Federal Water Pollution Control Act, as amended (codified at 33 USC 1251 et. seq.), Executive Order 11738, and Environmental Protection Agency (EPA) regulations which prohibit the use of facilities included on the EPA List of Violating Facilities. Any violations shall be reported to DHS, the Department of Health and Human Services and to the US EPA Assistant Administrator for Enforcement (EN-329).

C. Contractor and Subcontractor shall comply with all mandatory standards and policies that relate to resource conservation and recovery pursuant to the Resource Conservation and Recovery Act (codified at

42 USC 6962). Section 6002 of that Act 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 contained in 40CFR Parts 247-253.

D. If the sums payable to Contractor exceed $10,000, Contractor shall 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).

E. Contractor and any laboratories used by Contractor shall comply with the Clinical Laboratory Improvement Amendments (CLIA 1988) which require that:

All laboratory testing sites providing Services under this Agreement shall have either a Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver or a certificate of registration along with CLIA identification number. Those laboratories with certificates of waiver will provide only the eight types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.

F. Contractor shall comply with the requirements of 42 CFR Part 489, Subpart I Omnibus Budget Reconciliation Act (OBRA) 1990, Patient Self Determination Act and ORS Chapter 127 as amended by the Oregon Legislative Assembly 1993, pertaining to advance directives.

G. Contractor shall comply with all other applicable federal law.

H. If Contractor lets any subcontracts, Contractor shall take affirmative steps to: include qualified small and minority and women's businesses on solicitation lists, assure that small and minority and women's businesses are solicited whenever they are potential sources, divide total requirements into smaller tasks or quantities when economically feasible so as to permit maximum small and minority and women's business participation, establish delivery schedules when requirements permit which will encourage participation by small and minority and women's businesses, and use the Services and assistance of the Small Business Administration, the Office of Minority Business Enterprise of

the Department of Commerce and the Community Services Administration as required.

I. Contractor shall comply with all requirements of Exhibit I, Practitioner Incentive Plans, to ensure compliance with Sections 4204 (a) and 4731 of the Omnibus Budget Reconciliation Act of 1990 that concern physician incentive plans.

J. If Contractor is a Risk HMO and is sanctioned by CMS under 42 CFR 434.67, payments provided for under this Agreement will be denied for OHP Members who enroll after the imposition of the sanction, as set forth under 42 CFR 434.42.

K. Prevention/Detection of Fraud and Abuse

Contractor shall have in place internal controls, policies or procedures capable of preventing and detecting fraud and abuse activities as they relate to the Oregon Health Plan as outlined in Exhibit J.

L. Debarment and Suspension

Contractor shall not permit any person or entity to be a sub-contractor if the person or entity is listed on the non-procurement portion of the General Service Administration's "List of Parties Excluded from Federal Procurement or Nonprocurement Programs" in accordance with Executive Orders No. 12,549 and No. 12,689, "Debarment and Suspension". (See 45 CFR part 76). This list contains the names of parties debarred, suspended, or otherwise excluded by agencies, and contractors declared ineligible under statutory authority other than Executive Order No. 12549. Sub-contractors 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.

XXX. Agreement Compliance and Quality Assurance Monitoring

A. OMHAS shall conduct Agreement compliance and QA monitoring related to this Agreement. Contractor and its Subcontractors shall cooperate in such monitoring and Contractor shall notify its

Subcontractors and Participating Providers of such monitoring, related instructions and request for information.

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

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

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

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

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

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

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

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

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

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

F. OMHAS shall make available to Contractor a written report of its findings and conclusions within sixty (60) calendar days of the completion of the monitoring.

XXXI. Amendments and Termination

A. The terms of this Agreement shall not be waived, altered, modified, supplemented, or amended, in any manner whatsoever, without a duly executed amendment. Any amendments to this Agreement shall be effective only when reduced to writing, signed by both parties, and when signed by the Oregon Department of Justice as approved for legal sufficiency.

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

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

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

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

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

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

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

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

f. If Contractor fails to perform or otherwise comply with any provision contained in Section V, Statement of Work.

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

h. If Contractor is a county government (or a group of counties acting through a lead county under ORS Chapter 190 or an intergovernmental entity created by a group of counties under ORS Chapter 190) and no longer operates or contracts for CMHPs (or in the case of a group of counties acting through a lead county under ORS Chapter 190 or an

intergovernmental entity created by a group of counties under ORS Chapter 190, one or more of the said counties no longer operates or contracts for CMHPs) pursuant to ORS 430.620 under an Intergovernmental Agreement with DHS.

C. Notwithstanding paragraphs A and B of this subsection, if DHS initiates termination of this Agreement, Contractor may request an Agreement pre-termination hearing within ten (10) days of the Notice of Termination as follows:

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

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

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

   a. It will be conducted by the Administrator of OMHAS, or designee;

   b. No minutes or transcript of the meeting is required;

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

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

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

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

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

4. If Contractor timely requests an Agreement pre-termination hearing, the Administrator of OMHAS shall:

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

b. Permit such enrollees to disenroll immediately with Contractor without cause.

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

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

E. In the event of termination of this Agreement, the following provisions apply:

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

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

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

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

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

4. The rights and obligations of the parties arising under the following sections of Part II: Section V, Statement of Work, Subsection J, Recordkeeping, Item 3, Government Access to Records; Section XIX, Controlling State Law/Venue; Section XXV, Professional Liability Insurance; Section XXXI,

Amendments and Terminations, Subsection D and Subsection E, shall survive the termination or expiration of this Agreement.

XXXII. Notices

Any notice under this Agreement shall be deemed received the earlier of either the date of actual delivery or two (2) working days after mailing certified and postage prepaid through the U.S. Postal Service addressed as follows:

If to Contractor: To the address listed in Part I, Section V. Contractor Information, of this Agreement

If to an OHP Member: To the latest address provided for the OHP Member on an address list, Enrollment or change of address form actually received by Contractor.

If to DHS: OMHAS Community Services Section Manager, 2575 Bittern Street NE, Post Office Box 14250, Salem, Oregon 97309-0740.

EXHIBIT A
MENTAL HEALTH SERVICES PRACTITIONER REPORT

1. Contractor shall complete the Mental Health Services Practitioner Report and submit the report on a computer diskette using a spreadsheet format such as Excel, or a database format such as Access, to OMHAS within one calendar month after the effective date of this Agreement. Contractor may complete a separate report for each county included in its Service Area.

2. Contractor shall list the names of all Participating Providers contracted with for the provision of Covered Services under this Agreement.

   a. Contractor shall include the names of those employed persons whose duties may be administrative if such persons are responsible for oversight of clinical or Case Management activities; however, the amount of time recorded for such persons shall be limited to the proportion of time spent conducting clinical oversight or Case Management activities.

   b. Contractor shall indicate the average number of hours worked each week over the last three (3) months for Contractor employed Health Care Professionals. A "standard" work week, for the purposes of this report, shall be 40 hours.

      (1) Contractor may prorate the average number of hours worked each week using the following formula: the number of hours worked x percentage of OHP Members seen. For example, if 85% of total clients are OHP Members, multiply the total hours worked by each employed Health Care Professional by 85%.

      (2) Contractor may propose to OMHAS other methods to calculate the average number of hours per week by employed Health Care Professionals.

   c. For contracted Health Care Professionals, Contractor shall indicate the average number of hours worked each week over the last three (3) months in providing Covered Services to OHP Members.

3. Contractor's report shall include the following data elements:

   a. Name of MHO
   b. Report Date
   c. County, or counties, to which this report applies
   d. List name of each contracted individual mental health professional providing Covered Services to OHP Members by degree or license and indicate specialty using the following categories:

      (1) MD (Physician/Psychiatrist),
      (2) PMHP (Psychiatric Mental Health Nurse Practitioner),
      (3) PhD (Licensed Clinical Psychologist), or
      (4) LCSW (Licensed Clinical Social Worker).

   e. List name of each contracted agency showing employed clinical persons providing covered services or case management activities, and indicate the average hours per week each is engaged in OHP activities for the Contractor. Use the following categories:

      (1) MD (Physician/Psychiatrist),
      (2) PMHP (Psychiatric Mental Health Nurse Practitioner),
      (3) PhD (Licensed Clinical Psychologist),
      (4) LCSW (Licensed Clinical Social Worker),
      (5) QMHP (Qualified Mental Health Professional),
      (6) QMHA (Qualified Mental Health Associate), or
      (7) PARA/Non-D (Paraprofessional/Non-Degree).

   f. List the names of all other Participating Providers not included above with whom the Contractor has contracted for the provision of Covered Services under this Agreement such as hospitals, or Respite Care Providers.

4. Contractor shall send this report to Office of Mental Health and Addiction Services, Community Services Section, PO Box 14250, Salem, OR 97309-0740.

5. If Contractor has questions about this report, Contractor may call the OMHAS Quality Assurance Specialist at (503) 945-9829.

EXHIBIT B
MENTAL HEALTH ORGANIZATION (MHO) COMPLAINT LOG

1. Complaint means an oral or written communication, submitted by an OHP Member or an OHP Member Representative, which addresses issues with any aspect of the Contractor's or Provider's operations, activities, or behavior that pertains to 1) the availability, delivery, or Quality of Care, including utilization review decisions, that are believed to be adverse by the OHP Member; or 2) the denial, reduction, or limitation of Covered Services under this Agreement. The expression may be in whatever form or communication or language that is used by the OHP Member or the OHP Member Representative, but must state the reason for the dissatisfaction and the OHP Member's desired resolution.

2. An OHP Member, or OHP Member Representative, may relate any incident or concern to Contractor, Provider, or Subcontractor, by indicating or expressing dissatisfaction or concern, or by stating this is a Complaint that needs resolution.

3. Complaints are a source of information that may be used to evaluate the quality of access, Provider service, clinical care, or Contractor Service to OHP Members. Contractor shall have written policies and procedures for the thorough, appropriate and timely resolution of OHP Member Complaints, which include:

   a. Documentation of the nature of the Complaint which shall include, at minimum:
      1.) A log of formal Complaints;
      2.) A file of written formal Complaints and Grievances, and
      3.) Records of their resolution.
   b. Analysis and investigation of the Complaint; and
   c. Notification to the OHP Member of the disposition of the Complaint and the OHP Member's right to appeal the outcome of the Complaint or handling of a Complaint.

4. Contractor shall complete and submit the MHO Complaint Log on a quarterly basis within 60 calendar days of the end of each calendar quarter. Contractor shall record each Complaint <u>once</u> on the MHO Complaint Log. If the Complaint covers more than one category, Contractor shall record the Complaint in the predominant category.

5. Contractor shall send the MHO Complaint Log to Office of Mental Health and Addiction Services, Community Services Section, PO Box 14250, Salem, OR 97309-0740.

6. If Contractor has questions about this report, Contractor may call the OMHAS Quality Assurance Specialist at (503) 945- 9829.

7. If Contractor wants this report on diskette, Contractor may call (503) 945-9447.

MHO COMPLAINT LOG

Mental Health Organization_____Report Period:_____

An informal Complaint is defined as an incident or concern identified verbally related to a practitioner or staff member. This level of Complaint requires minimal research, and often is resolved through education, negotiation, mediation, case management, or change in policy.
A formal complaint is an incident or concern which is identified either verbally or in writing to the staff member(s) responsible for resolving Complaints and grievances and that require formal review by the Contractor's Quality Assurance Coordinator and/or Contractor's medical director. (Attach a brief narrative for formal Complaints).

Date Received	Type of Complaint (Select primary issue and write in item number from list)						Date of Resolution
	Access	Denial of Service, Authorization, or Payment	Clinical Care	Interaction with MHO, Provider, or Staff	Quality of Service	Consumer Rights	

Type of Complaint as you best understand the core issue following discovery

	ACCESS
A1	Difficulty contacting Provider or MHO
A2	Timely appointment not available
A3	Convenient appointment not available
A4	No choice of clinicians or clinician not available
A5	Transportation or distance barrier
A6	Physical barrier to Provider's office
A7	Language barrier or lack of interpreter services
A8	Wait time during visit too long
A9	Other (describe)
	Denial of Service, Authorization, or Payment
D1	Desired service not available
D2	Client wanted more service than offered/authorized
D3	Request for service not covered by OHP
D4	Request for medically unnecessary service
D5	Payment to non-participating provider denied
D6	Service authorization denied
D7	Other (describe)
	Clinical Care
C1	Client not involved in treatment planning
C2	Client's choice of service not respected
C3	Disagreement with treatment plan
C4	Concern about prescriber or medication issues
C5	Lack of response or follow-up
C6	Lack of coordination among providers
C7	Care not culturally appropriate
C8	Client believed quality of care inadequate
C9	Other (describe)

	Interaction with Provider, MHO, or Staff
I1	Client feels not treated with dignity or respect
I2	Client disagrees with staff or clinician response
I3	Lack of courteous service
I4	Lack of cultural sensitivity
I5	Other (describe)
	Quality of Service
Q1	Provider office unsafe
Q2	Provider office uncomfortable
Q3	Client did not receive information about available services
Q4	Excessive wait times on phone
Q5	Phone call not returned
Q6	Client doesn't like pre-authorization requirements
Q7	Other (describe)
	Consumer Rights
CR1	Not informed of consumer rights
CR2	Complaint and appeal procedure not explained
CR3	Access to own records denied
CR4	Concern over confidentiality
CR5	Allegation of abuse
CR6	Treatment discontinued without proper notification
CR7	Other (describe)

EXHIBIT C
SOLVENCY PLAN AND FINANCIAL REPORTING

Contractor shall maintain sound financial management procedures, maintain protections against Insolvency commensurate with the number of OHP Members and level of risk assumed, and generate periodic financial reports for submission to OMHAS (OAR 410-141-0340). Financial management, solvency protection, and reporting shall occur as specified below.

1. Contractor shall protect itself against catastrophic and unexpected expenses related to Covered Services by either self-insuring or by obtaining stop-loss protection from a private insurer in an amount sufficient to cover estimated risk for the duration of this Agreement. Contractor shall provide proof of such coverage to OMHAS within 30 days after the effective date of this Agreement.

2. Restricted Reserve Fund

   Contractor shall maintain a Restricted Reserve Fund balance no less than $250,000 and provide evidence of the required restricted reserve account balance to OMHAS within 60 calendar days after the end of each calendar quarter as outlined below. Contractor shall identify where and by whom the restricted reserve account is held.

   a. If Contractor subcontracts any work to be performed under this Agreement using a subcapitated reimbursement arrangement, Contractor may choose to require its Subcontractor to maintain a Restricted Reserve Fund for the Subcontractor's portion of the risk assumed or may maintain a Restricted Reserve Fund for all risk assumed under this Agreement. Regardless of the choice made, Contractor shall assure that the combined total Restricted Reserve Fund balance meets the requirements of this Agreement.

   b. If the Restricted Reserve Fund is held in a combined account or pool with other entities, Contractor, and its Subcontractors as applicable, shall provide a statement from the pool or account manager that the Restricted Reserve Fund is available to Contractor, or its Subcontractors as applicable, and has not been obligated elsewhere.

   c. If Contractor must use its Restricted Reserve Fund to finance Covered Services, Contractor shall provide advance written notice to OMHAS of the amount to be withdrawn, the reason for withdrawal, when and how the Restricted Reserve Fund will be replenished, and steps to be taken to avoid the need for future Restricted Reserve Fund withdrawals.

   d. Contractor shall provide OMHAS access to its Restricted Reserve Fund if Insolvency occurs.

e. Contractor shall have written policies and procedures to ensure that, if Insolvency occurs, OHP Members and related Clinical Records are transitioned with minimal disruption.

3. Contractor shall provide Third Party Resource collection information, using Report C2, Current OHP Members with Third Party Resources (Quarterly Report), on a quarterly basis within 60 calendar days after the end of each calendar quarter. Contractor shall make reasonable efforts to identify and pursue such Third Party Resource without regard to any capitation payments. Contractor shall keep records of such efforts, successful or unsuccessful, to ensure accuracy of such reports and make records available for audit and review upon request.

4. Contractor shall provide financial information, using Report C3, Quarterly Balance Sheet, within 60 calendar days after the end of Contractor's fiscal year. Contractor shall have systems that capture, compile, and evaluate information and data concerning financial operations including, but not limited to, the determination of future budget requirements and for determining, managing and accounting for "Incurred But Not Reported" expenses.

5. Contractor shall provide financial information, using Reports C4, MHO Contractor's Quarterly Statement of Revenue and Expenses, and C4A, Health Care Expenses By Service Type, on a quarterly basis within 60 calendar days after the end of each calendar quarter.

   In addition to the quarterly reports, Contractor shall provide a Report C4 based on a fiscal year which shall include a detailed description of how a net loss was covered or how a net income will be used during the next fiscal year.

6. Contractor shall provide financial information, using Report C5, Fiscal Year Cash Flow Analysis for Corporate Activity within 90 calendar days after the end of Contractor's fiscal year.

   a. Contractor shall submit an Annual Audited Financial Statement to OMHAS within 180 days after the end of the Contractor fiscal year. The audited financial statement shall be prepared by an independent accounting firm. In conducting the audit of the financial statements, the auditor will apply sufficient procedures to conclude that, in all material respects:

      (1) the assumptions and methods used in determining loss reserves, actuarial liabilities, or other related accounting items are appropriate in the circumstances, and
      (2) the information on the Contractor's C3, C4, C4a, and C5 reports is accurately included within the amounts presented in the Contractor's financial statements and footnote disclosures.

7. Contractor shall notify OMHAS of any significant change to the information provided in the quarterly financial reports. If the change requires restatement of a prior quarterly financial report, Contractor shall amend the report and submit to OMHAS within 30 working days of the date the change is identified.

8. Contractor shall supply OMHAS with a spreadsheet, or other mutually agreed upon format, containing the quarterly financial reports either electronically or by mailing a diskette. Contractor shall send these reports to Office of Mental Health and Addiction Services, Community Services Section, PO Box 14250, Salem, OR 97309-0740.

9. If Contractor has questions about these reports, Contractor may call the OMHAS, Community Services Section, OHP Contracts Coordinator at (503) 945-9447.

10. If Contractor wants these reports on diskette, Contractor may call (503) 945-9447.

REPORT C1:
MENTAL HEALTH MONTHLY UTILIZATION OVERVIEW

Mental Health Organization:_____

Report Period: _____through_____

Instructions: Provide monthly Utilization and OHP Member information for Covered Services. Due within 90 calendar days of the end of each month

1. OHP Member Information		**Number**
Total Number of OHP Members[1] As of the First of This Month		
Unduplicated Number of OHP Members Who Received Services This Month[2]		
2. Utilization: Outpatient Services	**No. of OHP Members Served[3]**	**No. of Units[4] of Services Provided**
Assessment and Evaluation		
Case Management		
Consultation		
Medication Management		
Outpatient Therapy		
Supportive Day Program		
Family Support Services		
Group Parent Psychosocial Skills Development		
Sign Language/Oral Interpreter Service		
MHDDSD JOBS		
2. Utilization: Outpatient Services	**No. of OHP Members Served[5]**	**No. of Units[6] of Services Provided**
Individual Parent Psychosocial Skills Development		
Other Services (Specify)		
3. Utilization: Inpatient and Alternatives to Inpatient Services	**No. of Discharges[7]**	**No. of Days[8]**
Acute Inpatient Hospital Care		
Subacute Care		
Respite Care		
Partial Hospitalization, Full Day		
Partial Hospitalization, Part Day		

Last Update 7/00

[1]The number of OHP Members the Contractor was capitated for as of the first calendar day of the reporting month.

[2]Count all OHP Members who received Covered Services during the month.

[3]The unduplicated count of OHP Members who received Covered Services within each service category.

[4]The total number of units of Covered Services provided to OHP Members counted in the previous column regardless of what entity paid for the service. For example, report Covered Services paid for by Medicare or other private insurance. Unless specified otherwise, a unit of service equals 15 minutes. An OHP Member may receive more than one type of service.

[5]The unduplicated count of OHP Members who received Covered Services within each service category.

[6]The total number of units of Covered Services provided to OHP Members counted in the previous column regardless of what entity paid for the service. For example, report Covered Services paid for by Medicare or other private insurance. Unless specified otherwise, a unit of service equals 15 minutes. An OHP Member may receive more than one type of service.

[7]The number of OHP Members discharged from an inpatient hospital or one of the alternatives listed below. Do not count as a discharge transfers from one facility to another when the receiving facility provides the same level of care and the care is covered by the Contractor under the MHO Agreement. OHP Members found Appropriate for Long Term Psychiatric Care but who remain in an Acute Inpatient Hospital Psychiatric Care setting should not be counted until physical transfer or discharge occurs. Count the discharge even when Medicare or other private insurance paid for the Covered Service.

[8]The sum of incurred inpatient days for each of the discharges recorded for the report period. Count and record days for only those discharges occurring during the reporting period. Count the total length of stay for each discharge. For OHP Members found Appropriate for Long Term Psychiatric Care but who remain in an Acute Inpatient Hospital Psychiatric Care setting, do not count the days from the point the OHP Member is deemed Appropriate for Long Term Psychiatric Care.

REPORT C2:
CURRENT OHP MEMBERS WITH THIRD PARTY RESOURCES (QUARTERLY REPORT)

Mental Health Organization:_____

Report Period: _____

Instructions: Due within 60 calendar days after the end of each calendar quarter.

1. Provide Third Party Resource information for Covered Services.
2. Separate amounts collected by Medicare, other insurance collections, and tort and estate collections, and Capitation rate category.
3. If the accounts receivable system cannot capture collections by Capitation rate category, do the following:
   a. Record total collections by Medicare, other insurance, and tort and estate recoveries.
   b. Keep detailed records of all collections by OHP Member name, prime number and Third Party Resource.
   c. Provide a written statement with the report indicating when Third Party Resource collection information will be available by Capitation rate category.

Capitation Rate Category	Medicare Collections	Other Insurance Collections	Tort and Estate Collections
1. TANF			
2. General Assistance			
3. PLM Adults under 100% FPL			
4. PLM Adults over 100% FPL			
5. SCHIP Children Aged 0 - 1			
6. PLM Children Aged 0 - 1			
7. PLM or SCHIP Children Aged 1- 5			
8. PLM or SCHIP Children Aged 6 - 18			
9. OHP Families			
10. OHP Adults & Couples			
11. AB/AD with Medicare			

12. AB/AD without Medicare			
13. OAA with Medicare			
14. OAA with Medicare Part B Only			
15. OAA without Medicare			
16. CAF Children			
17. Total Collections			

Last Update on 7/00

Preparer's Signature and Phone Number

REPORT C3:
QUARTERLY BALANCE SHEET

Mental Health Organization_____

Report Period: ☐ **4th Quarter (Oct-Dec)** ☐ **1st Quarter (Jan-Mar)**
☐ **2nd Quarter (Apr-Jun)** ☐ **3rd Quarter (Jul-Sep)**

Report due within 60 calendar days after the end of each calendar quarter.

Category	MHO Activities Under this Agreement
CURRENT ASSETS	
1. Cash and Cash Equivalents	
2. Short-Term Investments	
3. Investment Income Receivables	
4. Health Care Receivables	
5. Prepaid Expenses	
6. Other Current Assets	
7. Total Current Assets	
OTHER ASSETS	
8. Restricted Cash and Restricted Securities	
9. Other Long-Term Investments	
10. Other Assets (Please specify)	
(a)	
(b)	
(c)	
11. Total Other Assets	

Category	MHO Activities Under this Agreement
PROPERTY AND EQUIPMENT	
12. Land, Buildings and Improvements	
13. Furniture and Equipment	
14. Leasehold Improvements	
15. Other Property and Equipment	
16. Total Property and Equipment	
17. TOTAL ASSETS	
CURRENT LIABILITIES	
18. Accounts Payable	
19. Claims Payable	
20. Incurred but Not Reported	
21. Accrued Medical Incentive Pool	
22. Loans and Notes Payable	
23. Other Current Liabilities	
24. Stop Loss Insurance	
25. Total Current Liabilities	
OTHER LIABILITIES	
26. Loans and Notes Payable	
27. Other Liabilities	
28. Total Other Liabilities	
29. TOTAL LIABILITIES	
NET WORTH	
30. Contributed Capital	
31. Contingency Reserves	
32. Retained Earnings/Fund Balance	

Category	MHO Activities Under this Agreement
33. Other Net Worth	
34. Total Net Worth	
35. TOTAL LIABILITIES AND NET WORTH	

Preparer's signature and phone number

Report C3: Quarterly Balance Sheet

Other Definitions for this report:

Balance Sheet: A financial statement that has been developed using generally accepted accounting principles and that shows the financial position of a business on a particular date.

If separate accounts are not kept for Covered Services, balance sheet information for such Covered Services may be allocated using an estimation procedure. Such procedure and all assumptions must be disclosed in Notes. This estimation procedure must be used throughout the report.

1. **Cash and Cash Equivalents:** Cash in the bank or on hand, available for current use. Cash equivalents are investments maturing 90 calendar days or less from date of purchase.

2. **Short-Term Investments:** Principal amounts of investments in securities that are readily marketable, maturing one year or less from date of purchase.

3. **Investment Income Receivables:** Income, including interest accrued or dividends earned on short term or long term investments.

4. **Health Care Receivables:** Includes Fee-For-Service, coordination of benefits, subrogation, copayments, reinsurance recoveries and non-affiliated provider receivables.

5. **Prepaid Expenses:** Any expenses paid and recorded in advance of its use or consumption in the business, which properly represents a portion as an expense of the current period and a portion as an asset on hand at the end of the period.

6. **Other Current Assets:** Other assets not included in the asset categories listed above, including any other accounts receivable.

7. **Total Current Assets:** The sum of lines 1 through 6.

8. **Restricted Cash and Restricted Securities:** Assets restricted for statutory Insolvency requirements held for contract.

9. **Other Long-Term Investments:** Principal amounts of investments with a maturity longer than one year from date of purchase or no stated maturity date.

10. **Other Assets:** Other assets, such as aggregate write-ins, bonds, preferred stocks, receivables from securities, etc. (Please specify)

11. **Total Other Assets:** The sum of lines 8 through line 10.

12. **Land, Buildings and Improvements:** Net book value of land and buildings owned by Contractor, and any improvements made to buildings, or improvements in progress.

13. **Furniture and Equipment:** Net book value of office equipment, including computer hardware and software (where permitted), and furniture owned by Contractor.

14. **Leasehold Improvements:** Net book value of improvements to facilities not owned by Contractor. Provide net amount (gross amount less amortization).

15. **Other Property and Equipment:** Net book value of other tangibles and, fixed assets that are not included on Lines 12, 13, and 14.

16. **Total Property and Equipment:** The sum of lines 12 through line 15.

17. **Total Assets:** The sum of lines 7, 11 and 16.

18. **Accounts Payable:** Amounts due to creditors for the acquisition of goods and services (trade and vendors rather than health care practitioners) on a credit basis.

19. **Claims Payable:** Claims reported and booked as payables claims (minus incentives and stop loss).

20. **Incurred But Not Reported (IBNR):** An estimate for claims which have been incurred as of the last date of the report period for which Contractor is responsible but has not yet determined the specific amount of liability.

21. **Accrued Medical Incentive Pool:** Liability for arrangements whereby Contractor agrees to share Utilization savings with Individual Practice Associations, physician groups, or other providers.

22. **Loans and Notes Payable:** The principal amount on loans or notes due within one year.

23. **Other Current Liabilities:** Any payable amount other than direct health care services to affiliates and any liabilities not included in the current liabilities categories listed above.

24. **Stop Loss Insurance:** Protection against catastrophic and unexpected expenses related to Capitated Services. The method of protection may include the purchase of stop loss coverage, reinsurance, self insurance or any other alternative determined acceptable by OMHAS.

25. **Total Current Liabilities:** The sum of lines 18 through 24.

26. **Loans and Notes Payable:** Loans and notes signed by Contractor, not including current portion payable, that are of a long term nature (liquidation not expected to occur within one year of the date of the statement).

27. **Other Liabilities:** Other liabilities not included in the liabilities categories listed above.

28. **Total Other Liabilities:** The sum of lines 26 and 27.

29. **Total Liabilities:** The sum of lines 25 and 28.

30. **Contributed Capital:** Capital donated to Contractor.

31. **Contingency Reserves:** Reserves held for contingency purposes as defined in state statutes and regulations.

32. **Retained Earnings/Fund Balance:** The undistributed and unappropriated amount of surplus.

33. **Other Net Worth:** Other net worth items not reported on any other lines.

34. **Total Net Worth:** The sum of line 30 through 33.

35. **Total Liabilities and Net Worth:** The sum of lines 29 and 34.

REPORT C4:
MHO CONTRACTOR'S QUARTERLY STATEMENT OF REVENUE AND EXPENSES

Mental Health Organization:_____

Subcontractor:_____

Report Period: ☐ 4th Quarter (Oct-Dec) ☐ 1st Quarter (Jan-Mar)
☐ 2nd Quarter (Apr-Jun) ☐ 3rd Quarter (Jul-Sep)
☐ Annual Fiscal Year

Report due within 60 calendar days after the end of each calendar quarter.

❑ Full Accrual ❑ Modified Accrual ❑ Cash (Please Specify)

Category	OHP Activity under this Agreement
REVENUES	
1. Capitation	
2. ITS Pilot Payments (if applicable)	
3. Other Health Care Revenues (please specify)	
a.	
b.	
c.	
4. Total Revenues	

HEALTH CARE EXPENSES	
5. Health Care Expenses	
a. Staff Model	
b. Fee-for-Service	
c. Risk Models	
d. Other payment arrangements	
6. Incentive Pool and Withhold Adjustments	
7. Subcapitation Payments	
8. Other health care expenses not included above. (please specify)	
9. DEDUCTIONS	
a. Coordination of Benefits	
b. Reinsurance Recoveries Incurred	
c. Subrogation	
10. TOTAL HEALTH CARE EXPENSES	
ADMINISTRATIVE EXPENSES	
11.Contractor	
12.Subcontractor	
13.Total Adminstrative Expenses	
14. TOTAL EXPENSES	
15. NET INCOME (LOSS)[i]	
16. Beginning Balance	
17. Increase (Decrease) in Retained Earnings/Fund Balance	
18. Other Changes	
19 Balance at End of Period	

Accounting of Net Income (Loss) Recorded on Line 15 Contractor shall submit an additional Report C4 based on a fiscal year which includes a detailed description of how a net loss was covered or how a net income will be used during the next fiscal year

Line 15 Amount $_____

_____

Preparer's signature and phone number

[i] Contractor shall account for the amount of this line by providing an additional fiscal year C4. If the figure reflects a net loss, Contractor shall describe how the net loss was covered. If the figure reflects a net income, Contractor shall describe how such net income will be used during the next fiscal year.

Report C4: MHO Contractor's Quarterly Statement of Revenue and Expenses

Statement of Revenue and Expenses: A financial statement reporting fully accrued revenues and expenses under this Agreement for the period. Contractor shall indicate the accounting method used for this report: Full accrual, modified accrual, or cash basis. Expenses should be appropriately reported for health care and administrative expenses.

When a Contractor reports an expense on Report C4 Line 9 "Subcapitation payments", the Contractor shall have Subcontractors receiving subcapitation funds complete Reports C4 and C4A. Contractor shall attach Subcontractor's Reports C4 and C4A with Contractor's quarterly statements when submitting them to OMHAS .

OHP Activity: The financial position of Contractor relating to activities that are associated with Covered Services provided under the Oregon Health Plan (OHP) under this Agreement.

Allocation of expenditures between OHP and other line of business. If separate accounts are not kept for the OHP, revenue and expenses for the OHP may be allocated using an estimation procedure. Such a procedure and all assumptions must be disclosed in Notes to Report C4. This estimation procedure must be used throughout the reports. The assumptions underlying the allocation must be based on a methodology that clearly represents the costs associated with providing Covered Services to OHP Members.

Contractor shall indicate the beginning balance for the reporting period.

Revenues

1. **Capitation:** The amount received by Contractor on a per member per month basis in advance of and as payment for the provision of Covered Services to OHP Members enrolled with Contractor over a defined period of time.

2. **ITS Pilot Payments (if applicable)** - The amounts received by Contractor for OHP Members participating in the Intensive Treatment Services Pilot Project.

3. **Other Health Care Revenues:** Other revenues recognized as a result of other non-capitated arrangements between Contractor and OMHAS for Covered Services provided under this Agreement for OHP Members not included in the previous revenue categories. Please specify.

4. **Total Revenues:** The sum of lines 1 through 3.

HEALTH CARE EXPENSES : These are the costs that can be identified specifically with activities associated with providing services to OHP Members. Examples of health care costs are compensation of employees for the time devoted to activities associated with providing Covered Services to OHP Members, the cost of material acquired, consumed, or expended specifically for the purpose of such activities, equipment and capital expenditures specifically identified with such activities, and travel expenses incurred specifically to carry out such activities.

5. **Health Care Expenses:**

   a. **Staff Model:** Amounts paid by Contractor for the provision of Covered Services to enrolled OHP Members. Include salaries, fringe benefits, other compensations to staff engaged in the delivery of Covered Services and to personnel engaged in activities in direct support of the provision of Covered Services and other expenses as defined in health care expenses above. Exclude expenses for personnel time devoted to administrative tasks.
   b. **Fee for Service:** Amounts paid for the provision of Covered Services dependent on the actual number and nature of services provided to each OHP Member.
   c. **Risk Models:** Amounts paid where the Provider receives a fixed amount and assumes financial liability for the provision of Covered Services for OHP Members, such as DRGs or case rates.
   d. **Other Payment Arrangements:** Amounts paid under other Service payment arrangements not included in above categories.

6. **Incentive Pool and Withhold Adjustments:** Adjustments made to expenses that reflect the incentive pool and withhold activities.

7. **Subcapitation Payments:** Amounts paid by Contractor to a Provider in advance of and as payment for actual receipt of Covered Services, either on a per-member-per-month basis, or on the basis of a formula for allocation whereby the Provider assumes risk for the provision of all Medically Appropriate Covered Services to OHP Members who are enrolled with that Provider during the month.

8. **Other health care expenses not included above. (please specify)**

9. Deductions:

a. Coordination of Benefits: Income earned from Medicare, third party resources, and other insurance collections.

b. Reinsurance Recoveries Incurred: Amounts received from the reinsurer on paid losses and those amounts that have been billed to the reinsurer and not yet received.

c. Subrogation: Amounts received from other insurance recoveries, tort and estate collections.

10. Subtotal Health Care Expenses: The sum of lines 5 through 8 minus line 9.

ADMINISTRATIVE EXPENSES: Administrative costs are those associated with the overall management and operations of Contractor .

11. Contractor: All expenses by Contractor for administrative services such as claims and encounter processing, contract services, financial services, member services, provider relations, utilization management, and quality management.

12. Subcontractor: All expenses by Subcontractor for administrative services such as claims and encounter processing, contract services, financial services, member services, provider relations, utilization management, and quality management.

13. Total Administrative Expenses: The sum of lines 11 and 12.

14. Total Expenses: The sum of lines 10 and 13.

15. Net Income (Loss): The result of line 4 and 14.

If submitting this form as a fiscal year Report C4 and the amount reflects a net loss, then Contractor must describe how such loss was covered during the reporting period. If this figure reflects a net income, then Contractor must describe how the net income will be used in the next fiscal year.

16 Beginning Balance of Period: The total contributed capital, surplus notes, retained earnings/fund balance, and other items at the beginning of the report period.

17. Increase (Decrease) in Retained Earnings/Fund Balance: Changes in retained earnings/fund balance from the last report period to the current report period.

18. **Other Changes:** Changes in other items from the last report period to the current report period.

19. **Balance at End of Period:** Contributed capital, retained earnings/fund balance and other items at the end of the report period.

REPORT C4A:
HEALTH CARE EXPENSES BY SERVICE TYPE

Name of Mental Health Organization :_____

Subcontractor: _____

Report Period: ☐ **4th Quarter (Oct-Dec)** ☐ **1st Quarter (Jan-Mar)**
☐ **2nd Quarter (Apr-Jun)** ☐ **3rd Quarter (Jul-Sep)**

Report due at the same time as Report C4 – within 60 calendar days after the end of each calendar quarter.

Category	OHP Activity under this Agreement	Corporate Expenses
HEALTH CARE EXPENSES BY SERVICE TYPE		
1. Outpatient		
2. Sub Acute & Other 24 hour Services		
3. Inpatient		
4. Prevention, Education and Outreach		
5. Treatment Support Services & Supplies		
6. Consumer Operated Services		
7. Other Non-Encountered Services		
8. TOTAL HEALTH CARE EXPENSES[1]		

Last update 7/03

_____

Preparer's signature and phone number

[1] Total of line 8 "TOTAL HEALTH CARE EXPENSES" on Report C4A must equal line 10 "Total Health Care Expenses" on Report C4.

Report C4A: Health Care Expenses by Service Type

Contractor: Complete and attach Report C4A with its completed Report C4. Include all completed Reports C4 and C4A submitted by its Subcontractors with its own Report C4 and C4A.

Subcontractor: Complete and attach Report C4A with is completed Report C4, then submit the completed reports to the Contractor.

1. **Outpatient**: Expenses for covered health care services. Exclude expenses for personnel time devoted to administrative tasks.

2. **Sub Acute & Other 24 hour Services**: Expenses for services provided in lieu of hospitalization or as a step down from acute care hospitalization.

3. **Inpatient**: All inpatient hospital costs while confined to an Acute Inpatient Hospital Psychiatric Care setting.

4. **Prevention, Education and Outreach** : Outreach, Education and Prevention to OHP Members, not otherwise reportable as a service Encounter, treatment support services and supplies, or Consumer operated services. This category does not include marketing activities, provider training, or development and distribution of member handbooks.

5. **Treatment Support Services & Supplies**: Items or direct services provided to individuals as alternatives to Traditional Services and Flexible Services that are not otherwise reported as BA, CPT, HCPC, or ECC codes.

6. **Consumer Operated Services**: Supportive services provided by one or more consumers or a consumer run agency to groups and family members which cannot be captured as BA, CPT, HCPC or ECC codes. (e.g., a drop in center, telephone warm line, support group, etc.)

7. **Other Non**-Encountered Services: Other health care expenses for services not reported in above categories

8. **TOTAL HEALTH CARE EXPENSES**: The sum of lines 1 through 7. Total of line 8 "TOTAL HEALTH CARE EXPENSES" on Report C4A must equal line 10 "Total Health Care Expenses" on Report C4.

REPORT C5:
FISCAL YEAR CASH FLOW ANALYSIS FOR CORPORATE ACTIVITY-INDIRECT METHOD

MHO Contractor:_____

Report Period: _____through_____

Report is due within 90 calendar days after the end of Contractor's fiscal year.

Provide the cash flow information for Corporate Activity. Note that cash flow resulting from an increase in operating assets, a decrease in operating liabilities, and a payment out is a debit. Note that cash flows resulting in receipt of cash or proceeds are credits.

CASH FLOWS PROVIDED BY			MHO CORPORATE ACTIVITY
OPERATING ACTIVITIES		1. Net Income (Loss)	
	Adjustment to reconcile net income (loss to net cash)	2. Depreciation and Amortization	
	(Increase)/Decrease in Operating Assets	3. Health Care Receivables	
		4. Other Operating Costs	
		5. Claims Payable	
	Increase (Decrease) in Operating Liabilities	6. Unearned Capitation Amounts	
		7. Accounts Payable	
		8. Accrued Incentive Pool	
		9. Other Operating Activities	
10. NET CASH PROVIDED (USED) FROM OPERATING ACTIVITIES			

Report C5:
Fiscal Year Cash Flow Analysis for Corporate Activity
Indirect Method (Continued)

		MHO Corporate Activity
CASH FLOW PROVIDED BY INVESTING ACTIVITIES	11. Receipts from Investments	
	12. Receipts for Sales of Property and Equipment	
	13. Payments for Investments	
	14. Payments for Property and Equipment	
	15. Other Increase (Decrease) in Cash Flow for Investing Activities	
16. NET CASH PROVIDED BY INVESTING ACTIVITIES		
CASH FLOW PROVIDED BY FINANCING ACTIVITIES	17. Proceeds from Paid in Capital or Issuance of Stock	
	18. Loan Proceeds	
	19. Principal Payments on Loans	
	20. Dividends Paid	
	21. Principal Payments under Lease Obligations	
	22. Other Cash Flow Provided by Financing Activities	
23. NET CASH PROVIDED BY FINANCING ACTIVITIES		
24. NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS		
25. CASH AND CASH EQUIVALENTS AT BEGINNING OF REPORT PERIOD		
26. CASH AND CASH EQUIVALENTS AT END OF REPORT PERIOD		

Preparer's signature and phone number)

Report C 5: Fiscal Year Cash Flow Analysis for Corporate Activity – Indirect Method

Contractor shall provide a Cash Flow Analysis report based on the corporate fiscal year within 60 days after the end of that fiscal year.

MHO Corporate Activity: Total financial information of any relevant organization, partnership, or joint venture incorporated under or subject to the provisions of ORS Chapters 60, 65, 190 and 732.005. The Corporate Activity for each Contractor is defined in Part I of this Agreement.

CASH FLOW PROVIDED BY OPERATING ACTIVITIES: Financial report estimating cash generated or lost from operating activities.

1. **Net Income** (Loss): Report Corporate Activity on Report C4, Line 14 for the current quarter.

2. **Depreciation and Amortization:** Depreciation on property and equipment, and amortization on land.

3. **Health Care Receivable:** Report any cash flow generated or lost by changes in health care receivables. Include non-cash or non-cash equivalent transactions. Remove the effects of all deferrals of receipts and payments and accruals of receipts and payments.

4. **Other Operating Assets**: Report any cash flow generated or lost by changes in other operating assets. Include non-cash or non-cash equivalent transactions. Remove the effects of all deferrals of receipts and payments and accruals of receipts and payments.

5. **Claims payable:** Report any cash flow generated or lost by changes in claims payable. Include non-cash or non-cash equivalent transactions. Remove the effects of all deferrals of receipts and payments and accruals of receipts and payments.

6. **Unearned Capitation Amounts:** Report any cash flow generated or lost by changes in unearned capitation. Include non-cash or non-cash equivalent transactions. Remove the effects of all deferrals of receipts and payments and accruals of receipts and payments.

7. **Accounts Payable**: Report any cash flow generated or lost by changes in accounts payable. Include non-cash or non-cash equivalent transactions. Remove the effects of all deferrals of receipts and payments and accruals of receipts and payments.

8. **Accrued Incentive Pool:** Report any cash flow generated or lost by changes in accrued incentive pool. Include non-cash or non-cash equivalent transactions. Remove the effects of all deferrals of receipts and payments and accruals of receipts and payments.

9. **Other Operating Activities**: Report any other cash flow generated or lost by changes in other operating liabilities. Include non-cash or non-cash equivalent transactions. Remove the effects of all deferrals of receipts and payments and accruals of receipts and payments.

10. **NET CASH PROVIDED (USED) FROM OPERATING ACTIVITIES:** Sum of lines 1 through 9. To arrive at net cash provided by operating activities, remove from net income the effects of all deferrals of receipts and payments and accruals of receipts and payments.

CASH FLOWS PROVIDED BY INVESTING ACTIVITIES: Financial report showing the cash generated or lost from different investing activities.

11. **Receipts from Investments**: Cash generated by the transfer of cash out of either short-term or long-term investment transactions, including restricted cash reserves and other assets which relate to transactions reported in Report C3.

12. **Receipts for Sales of Property and Equipment:** Cash generated by the transfer of cash into property and equipment sales transactions reported in Report C3. Include any advance payments, down payments or other payments made at the time of purchase or shortly before or after the purchase of the property and equipment and productive assets including leasehold improvements.

13. **Payments for Investments**: Cash lost by the transfer of cash into either short-term or long-term investment transactions reported in Report C3. Include cash lost by transfer of cash into restricted cash reserves and other assets which relate to transactions reported in Report C3.

14. **Payments for Property and Equipment:** Cash lost by the transfer of cash into property and equipment sales transactions reported in Report C3. Include advance payments, down payments, or other amounts paid at the time of purchase or shortly before or after the purchase of the property and equipment.

15. **Other Increase (Decrease) in Cash Flow for Investing Activities**: Report any other cash flow generated or lost by changes in investing activities.

16. **NET CASH PROVIDED BY INVESTING ACTIVITIES:** Sum of lines 11 through 15.

CASH FLOWS PROVIDED BY FINANCING ACTIVITIES: Financial report showing the cash generated or lost from different financing activities.

17. **Proceeds from Paid in Capital or Issuance of Stock**: Cash generated by the transfer of cash from paid in capital surplus or issuance of stock.

18. **Loan Proceeds:** Cash generated by the transfer of cash from loan proceeds transactions.

19. **Principal Payments of Loans**: Cash lost by the transfer of cash from loan proceeds transactions.

20. **Dividends Paid**: Cash lost by paying dividends reported in Report C3.

21. **Principal Payments under Lease Obligations:** Cash lost by the transfer of cash from loan proceeds transactions from lease obligations. Include loans and notes payable transactions reported in Report C3.

22. **Other Cash Flow Provided by Financing Activities**: Any cash flow generated or lost by the transfer of cash in a financial transaction.

23. **NET CASH PROVIDED BY FINANCING ACTIVITIES:** Sum of lines 17 through 22.

24. **NET INCREASE /(DECREASE) IN CASH AND CASH EQUIVALENTS**: The sum of lines 10, 16 and 22.

25. CASH AND CASH EQUIVALENTS AT BEGINNING OF REPORT PERIOD: The total net cash provided by operating activities, by investing activities, and by financing activities at the beginning date specified in the report period on Report C5.

26. CASH AND CASH EQUIVALENTS AT END OF REPORTING PERIOD: The sum of lines 23 and 24.

EXHIBIT D
ENCOUNTER MINIMUM DATA SET REQUIREMENTS

1. General Provisions:

   a. Contractor shall submit data concerning OHP Member Encounters as described in this Exhibit and using submission requirements established by DHS.

   b. DHS shall process Encounter data through the Medicaid Management Information System (MMIS). DHS shall "pend" all Encounters that cannot be processed because of missing or erroneous data.

      (1) DHS shall notify Contractor weekly of all pended Encounters.

      (2) Contractor shall correct all pended Encounters, within the time period identified in 1.c.(3), below.

   c. Timelines

      (1) Contractor shall submit at least 50% of all Encounter data Contractor collects and/or adjudicates in a month to DHS at least once per calendar month.

      (2) Contractor shall submit all original Encounter data to DHS within 180 days of the date of service. Circumstances not subject to the 180 day time frame include 1) member's failure to give provider necessary claim information, 2) third party liability coordination, and 3) delays associated with resolving out-of-area claims. Contractor shall structure its subcontracts and Participating Provider reimbursement arrangements to ensure timely submission of billings.

      (3) Contractor shall submit all corrections to pended Encounters to DHS within 63 calendar days of the date that DHS mails Contractor a notice that the Encounters were pended.

(4) Contractor shall submit Encounter data for Covered Services known to have been provided to OHP Members. Contractor shall submit such Encounters regardless of the reimbursement method used, claim payment status (the claim was denied), placement on the Prioritized List of Health Services, or Third Party Resource status.

d. Data Transmission and Format

(1) Contractor shall submit all Encounter data to DHS via electronic media. DHS shall accept data via industry standard modem and cartridge media.

(2) Contractor shall submit all data in a format approved by DHS.

(3) Contractor may have another entity submit Encounter data on its behalf, however, Contractor shall request approval of such arrangement from the Technical/Encounter Data Services Subunit, Program Operations Unit, DHS. Contractor shall remain responsible for Encounter data accuracy, timeliness and completeness regardless of the entity submitting the Encounter data.

2. Data Set Requirements

a. The data elements specified in this section constitute the required minimum data set. Contractor is required to submit all of the data specified in this section.

b. Contractor shall submit the following identifying information for all Encounters:

(1) Contractor's DHS Prepaid Health Plan Provider Number

(2) OHP Member Name

(3) Medicaid Recipient Number, also known as the OHP Prime Number

(4) Disposition of the claim (accepted/rejected)

(5) Disposition Reason

c. For outpatient mental health Encounters, in addition to the identifying information listed in subsection 2.b., Contractor shall submit the following information:

(1) DHS Performing Provider Number

(a) Contractor shall use the number assigned to the CMHP of the Health Care Professional delivering Covered Services to the OHP Member. If Covered Services are rendered by Health Care Professionals not associated with a CMHP, then Contractor shall request and use a special performing provider number by submitting a request to OMHAS.

(b) Contractor shall not use DHS Provider Number "999999" for the performing provider number, billing provider number, or attending physician number. Use of such numbers shall result in a pended Encounter.

(2) Diagnosis Codes

Contractor shall use up to three fields to record the diagnostic code from the most current listing of the DSM. DSM Codes shall be reported at the highest level of specificity for each field as follows:

(a) Field 1: Record the principal Axis I or Axis II Diagnosis code.

(b) Field 2: Record any other applicable Axis I or Axis II Diagnosis code.

(c) Field 3: Record any other applicable Axis I or Axis II Diagnosis code, not already recorded in Fields 1 or 2.

(3) Function Score

Contractor shall use Field 4 to record either the current Axis V, global assessment of functioning (GAF) score 0-100 or the current CGAS if the OHP Member is a child. This information shall be reported for every OHP Member Encounter.

(4) Date(s) of Service

(5) Procedure Codes (BA/ECC Codes, HCPC or CPT Codes or other codes approved by DHS for use in submitting Encounter data)

(6) Number of Units of Service Provided

(7) Usual and Customary Charges

d. For Acute Inpatient Hospital Psychiatric Care Encounters, in addition to the identifying information listed in subsection 2.b., Contractor shall submit the following information:

(1) DHS Hospital Provider Number

(2) Type of Admission Code

(3) Patient Discharge Status Code

(a) Contractor shall use discharge codes established by DHS in its Hospital Services Guide.

(b) If the OHP Member is found Appropriate for Long Term Psychiatric Care during the Acute Inpatient Hospital Psychiatric Care stay, Contractor shall use a discharge code of 05.

(4) Dates of Service (dates from admission through discharge)

(5) Revenue Codes

(a) Contractor shall use revenue codes specific to the services provided. If Contractor has a limited number of special "package" services for which it pays an all-inclusive fee and is unable to provide specific revenue codes for those services, Contractor may use revenue codes approved in advance by the DHS Technical/Encounter Data Services Subunit, Program Operations Unit.

(b) Contractor shall submit a list and description of packaged services to DHS for which Contractor is seeking a special revenue code. DHS may request additional information about "package" services or Encounters using "package" revenue codes at any time and may discontinue the use of "package" revenue codes at its discretion with 30 calendar days notice to Contractor.

(6) Line Item Charges

(7) Total Charges

(8) Diagnosis Code(s) at the highest level of specificity.

(9) ICD-9 Procedure Codes when a procedure is performed

(10) Attending Physician DHS Performing Provider Number

e. For Outpatient Hospital Encounters, in addition to the identifying information listed in subsection 2.b., Contractor shall submit the following information:

(1) DHS Hospital Provider Number
(2) Revenue Center Code(s)
(3) Date of Service for each line item
(4) Quantity of units of service provided
(5) Line-item Charge(s) based on the usual and customary fee
(6) Diagnosis Code(s) at the highest level of specificity
(7) Procedure Codes for the Revenue Center Codes
(8) Attending Physician DHS Performing Provider Number

f. Contractors must submit one claim per hospitalization. The claim must represent all hospital services delivered to the OHP Member. Interim and late billings are prohibited. Additional services or revisions to the original claim must be handled through the adjustment process.

g. Contractors must make adjustments to claims when any required data elements change or Contractor discovers the data was incorrect or no longer valid.

h. Contractors must delete any duplicate claims within 63 calendar days of the date DHS notifies Contractor that the claim is a duplicate.

3. Data Certification and Validation

   a. Contractor must certify, based on best knowledge, information, and belief, that the Encounter data submitted for OHP Members is accurate and complete.

   b. Contractor shall submit the Data Certification and Validation Signature Authorization Form, Report D1, within 30 days following the effective date of this Agreement, and immediately following any changes.

   c. Contractor shall submit a Data Certification Form, Report D2, with each Encounter submission. In response to the receipt of Report D2, DHS Encounter Data Liaison will provide Contractor with information identifying any out-of-balance Encounter claim counts. Contractor will evaluate this information and work with the DHS Encounter Data Liaison to resolve any areas of possible data submission problems.

REPORT D1:
DATA CERTIFCATION AND VALIDATION
SIGNATURE FORM

Name of MHO:_____

Report due within 30 days of effective date of this Agreement, and immediately following any changes.

Contractor, or designee, must attest, based on best knowledge, information and belief, to the accuracy, completeness and truthfulness of the Encounter data and/or information submitted to DHS.

Signature, full name and title of the person(s) with authorization to certify the Encounter data and information submitted to DHS.

_____	_____
Authorized Signature	Authorized Signature
_____	_____
Name (please print)	Name (please print)
_____	_____
Title	Title
_____	_____
Telephone Number	Telephone Number
_____	_____
Authorized Signature	Authorized Signature
_____	_____
Name (please print)	Name (please print)
_____	_____
Title	Title
_____	_____
Telephone Number	Telephone Number

REPORT D2:

DATA CERTIFICATION FORM[1]

Name of MHO:_____

MHO Plan Number:_____

Date or Week Ending:_____

Contractor must submit this report with each Encounter data submission.

Total Claim Count		Total Billed Amount	

_____
Authorized Signature

_____ _____
Name (please print) Title

_____
Date

[1] If Contractor has the ability to send an "electronic signature document", please contact the DHS Encounter Data Liaison.

EXHIBIT E
CLIENT PROCESS MONITORING SYSTEM

The Client Process Monitoring System (CPMS) tracks community-based treatment services for persons with mental illness, persons with developmental disabilities, and persons with substance abuse problems. Information from this system is combined with other information from other systems to create one integrated database under a single unique client identifier. The integrated database contains Consumer specific data across programs statewide and provides a Continuity of Care picture for individual Consumers. This information allows OMHAS to manage publicly funded mental health services, respond to legislative inquiries, and demonstrate cost effectiveness under the federal requirement for the OHP Medicaid Demonstration Project and State Children's Health Program.

1. General Provisions:

   a. Contractor shall submit CPMS data for all OHP Members receiving Covered Services (except for acute inpatient hospital services which shall be reported on OP/RCS).

   b. Contractor shall submit CPMS data for any OHP Member who is civilly committed to the custody of DHS under ORS 426.130.

   c. OMHAS shall process all CPMS data through the Mental Health Information System (MHIS). OMHAS shall "pend" CPMS data that cannot be processed because of missing or erroneous date.

      (1) OMHAS shall notify Contractor monthly of all pended CPMS data.

      (2) Contractor shall correct pended CPMS data within 30 calendar days of notice.

   d. Timeliness

      (1) Contractor shall work with OMHAS Data Base Analyst in developing, formatting and testing the CPMS to ensure reporting of accurate data.

      (2) Contractor shall submit CPMS data to OMHAS for those OHP Members meeting the criteria described above in Section 1. within the time frames specified below in Section 2.b.

e. Data Transmission and Format:

(1) Contractor shall submit all CPMS data to OMHAS via electronic media in the specific CPMS format. Contractor may obtain reporting protocols upon request through the OMHAS Data Base Analyst.

(2) Contractor may request electronic access to the MHIS for Utilization monitoring purposes.

2. Data Set Requirements

a. Contractor shall submit all of the data specified in this Section for OHP Members meeting the criteria described above in Section 1. and may develop a database to collect and store data reported electronically to the Client Process Monitoring System.

b. Contractor shall submit, within 30 calendar days of an OHP Member meeting the criteria described above in Section 1. and within 30 calendar days of terminating current Treatment services for such an OHP Member, the following CPMS information.

Data Element	Treatment Begin	Treatment End	Reported Quarterly
Client County of Residence	X		
Clinic or Service Provider	X		
Date of Birth	X		
Diagnosis	X	X	
Education	X		
Employment Status	X		
Gender	X		
Level of Functioning	X	X	X
Living Arrangement	X		
MHIS Number	X		
Name, Birth	X		
Name, Full	X		
Plan or Contractor Identifier	X		
Presenting Dangers		X[1]	
Prime Number	X		

Provider or Clinic Case No.	X	
Race/Ethnicity	X	
Referred From	X	
Termination Referral		X
Termination Type/Reason		X

1 Data element to be reported upon end of Urgent/Emergency Service only.

EXHIBIT F
OREGON PATIENT/RESIDENT CARE SYSTEM

The Oregon Patient/Resident Care System (OP/RCS) contains information on all Consumers served at any of the state psychiatric hospitals, developmental disability training centers and psychiatric Acute Care facilities.

1. Contractor shall cooperate with OMHAS in establishing the electronic means to enter OP/RCS data at the hospital or facility providing Acute Inpatient Hospital Psychiatric Care Services under this Agreement.

    a. Contractor shall provide OMHAS with a list of hospitals to be used in delivering Acute Inpatient Hospital Psychiatric Care.

    b. Contractor shall identify the name, title and phone number of the person within each hospital with whom OMHAS will work to establish the computer hook-up to OP/RCS.

    c. Contractor shall identify the names, titles and phone numbers of persons within each hospital with whom OMHAS will work to maintain the accuracy, timeliness and completeness of OP/RCS data submission.

    d. Contractor shall work with OMHAS and hospital contact person in designating a physically secure (locked doors and limited access) location (floor and room number within hospital) of the stand alone computer to be used to enter OP/RCS data.

    e. Contractor shall assure that hospital contact persons comply with confidentiality requirements contained in 45 CFR Parts 160 and 164, Subparts A and E, to the extent that they are applicable, and consistent with other state law or federal regulations governing privacy and confidentiality of mental health information, sign the request for access/assurance of confidentiality form, and return the form to OMHAS.

2. Contractor or its Subcontractors shall electronically submit, within 12 hours of admission to Acute Inpatient Hospital Psychiatric Care, OP/RCS information for Acute Inpatient Hospital Psychiatric Care Services provided to OHP Members as indicated in the following table.

Data Element	Admission	Discharge
Commitment Type Code[1]	X	
County of Residence	X	
County of Responsibility	X	
County of Discharge		X
County of Commitment	X	
Date of Commitment	X	
Date of Admission/Discharge	X	X
Date of Diagnosis		X
Date of Birth	X	
Discharge Reason Code		X
Driving Status		X
DSM, Axis V Diagnoses		X
DSM, Axis IV Diagnoses		X
DSM, Axis I Diagnoses	X	X
DSM, Axis III Diagnoses	X	X
DSM, Axis II Diagnoses	X	X
Education Level Achieved	X	
Ethnic Category Code	X	
Living Arrangement Code	X	X
Marital Status Code	X	
Name	X	
Name, Alias	X	
Oregon Driver's License Number	X	
ORS Reference Numbers	X	
Patient Number	X	
Referral Source Code	X	X
Sex	X	
Social Security Number	X	

[1] The Commitment Type Code is changed/updated as applicable.

Data Element	Admission	Discharge
Status of Harm to Property	X	
Status of Harm to Others	X	
Status of Suicide	X	
Status of Harm to Self (Non-Suicide)	X	
Time of Admission/Discharge	X	X
Time of Commitment	X	

EXHIBIT G
OREGON HEALTH PLAN MENTAL HEALTH SERVICES
CLIENT NOTICES, GRIEVANCE, APPEALS, AND HEARINGS PROCESS

Contractor shall have written policies and procedures for a Grievance and Appeal process and access to the DHS administrative hearing process. An OHP Member or OHP Member Representative may file a Grievance or an Appeal either orally or in writing. Contractor may not discourage OHP Member's, or OHP Member Representative's, use of the DHS administrative hearing process, however any hearing request made outside of Contractor's Grievance and Appeal process shall be reviewed by Contractor upon notification by OMHAS.

1. Client Notices

   a. Contractor shall issue a written Notice of Action in a form meeting the OHP Member's special needs, to the OHP Member or OHP Member Representative, each time a Service or benefit will be terminated, suspended or reduced; each time a request for Service authorization is denied or limited; or a request for claim payment is denied in whole or in part. A Notice of Action shall be mailed to the OHP Member or OHP Member Representative:
      (1) For termination, suspension, or reduction of Services, at least ten (10) days before the date of action;
      (2) For denial of payment, at the time of any action affecting the claim;
      (3) For Service authorization requests, when a decision is made to deny the Service authorization request, or to authorize an amount, duration, or scope that is less than requested; or on the date when timeframes expire when a decision is not made for either a standard or expedited Service authorization request; or
      (4) If probable OHP Member fraud has been verified, the period of advanced notice is shortened to 5 days.

      Notice of Action shall be written using easily understood language, translated into the non-English language spoken by the OHP Member, and in an alternate format identified by the OHP Member.

b. A Notice of Action shall inform the OHP Member of the following:

(1) A statement of the action, and the effective date of such action;

(2) Reasons for the action;

(3) The OHP Member's right to file an Appeal with Contractor and request an administrative hearing with DHS;

(4) The method by which the OHP Member may obtain an administrative hearing;

(5) In the event the OHP Member feels the mental health problem cannot wait for the normal Appeal process, how to request an Expedited Appeal;

(6) The OHP Member's right to request continuation of Services until a decision is rendered. The OHP Member shall also be informed that any Services continued may have to be repaid by the OHP Member if the issue is resolved in favor of Contractor; and

(7) The name and telephone number of a person to contact for additional information.

c. The OHP Member or OHP Member Representative who files an Appeal shall receive a written decision from Contractor. A copy of the Notice of Hearing Rights (OHP-0505-3/98) and Administrative Hearing Request Form (AFS 443) shall be attached to the written decision.

d. Contractor shall make available in all clinics frequented by OHP Members information concerning client notices, Grievances, Appeals, and hearings processes.

e. Contractor must reinstate services if:

(1) Contractor takes an action to deny, reduce, or discontinue services without providing the required notice; or

(2) Contractor does not provide the notice in the time specified above in Section 1. A., Client Notices, and the OHP Member requests a

hearing within ten (10) days of the mailing of the notice of action; or

(3) The US Postal Service returns mail directed to the OHP Member, but the OHP Member's whereabouts become known during the time the OHP Member is eligible for service.

2. Handling of Appeals

a. Contractor shall ensure that decision makers for Appeals were not involved in previous levels of review or decision-making and are mental health care professionals with clinical expertise in treating the OHP Member's mental health condition if any of the following apply:

(1) An Appeal of a denial based on lack of Medical Appropriateness;
(2) A Grievance regarding the denial of a request for an expedited process; or
(3) Any Appeal involving clinical issues.

b. OHP Member or OHP Member Representative may file an Appeal either in writing or orally, but must follow an oral filing with a written Appeal, unless the OHP Member or OHP Member Representative requests an expedited process.
c. Contractor shall provide the OHP Member or OHP Member Representative an opportunity to present evidence for an Appeal in person as well as in writing. Contractor must inform the OHP Member of the limited time available for this in the case of an expedited process.
d. Contractor shall provide the OHP Member or OHP Member Representative with an opportunity, before and during the Appeals process, to examine the OHP Member's clinical records, consistent with state law or other federal regulations governing privacy and confidentiality of mental health records, and any other documents and records, considered during the Appeals process.
e. An OHP Member or OHP Member Representative may file an Appeal with Contractor within a reasonable timeframe that cannot be less than 20 days and not to exceed 90 days from the date of the Notice of Action.

3. Continuation of Services Pending Appeal Resolution

a. If the OHP Member or OHP Member Representative wishes to have Services continued while the Appeal is being resolved, the OHP Member or OHP Member Representative must file the Appeal with Contractor before the effective date of the action or within ten calendar days after the date of the

Notice of Action was mailed or given to the OHP Member or OHP Member Representative. If the OHP Member or OHP Member Representative requests continuation of Services, Contractor must continue Services if:

(1) the Appeal was filed in a timely manner;
(2) appeal involves termination, suspension, or reduction of a previously authorized course of treatment;
(3) Services were authorized by a Participating Provider; or
(4) the original authorization has not expired.

b. If Contractor continues or reinstates Services while the Appeal is pending, Services must be continued until one of the following occurs:
   (1) the OHP Member withdraws the appeal;
   (2) ten days pass after Contractor mails OHP Member notice of the resolution of the appeal, unless the OHP Member within the 10-day timeframe has requested an administrative hearing; or
   (3) The original authorization expires.

4. Expedited Appeals

a. The OHP Member is only entitled to an expedited Appeal process if the mental status of the OHP Member meets the definition of an Emergency Situation or Urgent Situation and the situation cannot wait to be addressed within the time frames associated with a regular Appeal.

b. If the OHP Member's situation is consistent with criteria described above in Section (2), the OHP Member or OHP Member Representative may request an expedited Appeal process by indicating such in the place provided on the form and then explain why a decision is needed right away.

c. For an expedited Appeal, Contractor shall provide the OHP Member or OHP Member Representative with a response no later than three (3) working days after Contractor receives the request for an expedited Appeal.

d. If Contractor denies an OHP Member or an OHP Member Representative request for an expedited Appeal, Contractor must follow the timeframe for standard Appeals. Contractor shall make reasonable efforts to give OHP Member or OHP Member Representative prompt oral notice and follow up within two calendar days with a written notice.

5. Resolution of Appeals

a. Contractor must resolve each Appeal and provide notice of the resolution of the Appeal within 45 days from the date Contractor receives the Appeal.

b. Contractor may extend the timeframe by up to fourteen (14) days if the OHP Member requests the extension or if Contractor shows that there is need for additional information and how the delay is in the OHP Member's interest. For any extension not requested by OHP Member or OHP Member Representative, Contractor must give the OHP Member or OHP Member Representative written notice of the reason for the delay.

c. Contractor must provide written notice of the disposition that includes outcome and date of the resolution. If the decision is not in the OHP Member's favor, notice must include OHP Member's right to request an administrative hearing and the process to request a hearing, the OHP Member's right to request continuation of services pending a hearing and that the OHP Member may be held responsible for the cost of continued Services if the hearing is in favor of Contractor.

6. Grievances

a. OHP Member or OHP Member Representative may file a Grievance either orally or in writing. If the OHP Member or OHP Member Representative expresses dissatisfaction or a concern orally, the individual receiving such information shall ask the OHP Member or OHP Member Representative whether the expression of dissatisfaction or concern is something that needs resolution. If the OHP Member or OHP Member Representative indicates that resolution is desired, the person receiving the expression of dissatisfaction or concern shall describe the Grievance process, provide written materials, and request the OHP Member or OHP Member Representative to put the Grievance in writing. Contractor shall make staff available to help the OHP Member or OHP Member Representative put the Grievance in writing if requested or it appears assistance is needed.

b. Contractor shall review the Grievance and determine whether additional information is needed from the OHP Member, the OHP Member Representative, or the provider to address the issue.

c. If Contractor determines that additional information is needed from the OHP Member or OHP Member Representative, Contractor shall notify the OHP Member or OHP Member Representative that additional information is needed and must be furnished to Contractor within ten calendar days or another mutually agreed upon time frame or the Grievance may be resolved without this information.

d. If Contractor Representative determines that additional information is needed from the provider, Contractor Representative shall obtain such information as quickly as possible.

e. Contractor shall determine whether the issue can be resolved within 20 calendar days of receipt and shall address the Grievance within this time period, if possible. If the issue cannot be resolved within 20 calendar days, Contractor shall notify the OHP Member or OHP Member Representative in writing that a decision regarding the Complaint cannot be made within 20 calendar days. This notice must:

(1) Be issued as soon as it is known that a delay will occur;
(2) State when a decision will be made; and
(3) Specify the reason for the delay.

f. Contractor shall issue to the OHP Member or OHP Member Representative a written decision on the Grievance issue. The decision shall review and specifically address each element of the Grievance. If the decision is adverse to the OHP Member, the written notice issued shall include all elements of a Notice of Action and shall include the Administrative Hearing Request form.

3. Grievance and Appeal Resolution

Contractor shall have the following responsibilities in resolving disagreements with OHP Members and/or OHP Member Representatives:

a. Have written procedures for accepting, documenting, processing, analyzing, resolving and responding to all Grievances and Appeals made and DHS administrative hearings requested by OHP Members or OHP Member Representatives.

b. Designate staff members to handle Grievances and Appeals received and DHS administrative hearings requested by OHP Members or OHP Member

Representatives. The designees shall be persons with the authority and expertise necessary to make a final clinical or administrative decision at the Contractor level.

c. Have a method of informing its Participating Providers of the Grievance and Appeal process and DHS administrative hearings procedures, monitoring Participating Providers compliance with such procedures, and taking corrective action to assure Participating Providers compliance with procedures and reporting requirements.

d. Have a method of informing OHP Members about the Grievance and Appeal process and the DHS administrative hearings procedures. Information provided to OHP Members shall include the following:

(1) Written material, or alternative forms as required by the OHP Member's special need, describing these processes;

(2) Assurance that clinical information related to the Grievance and Appeal or DHS administrative hearing issue will be kept confidential except to the extent that sharing of such information between Contractor and DHS , and other persons authorized by the OHP Member, is necessary to resolve the issue;

(3) Availability of Grievance and Appeal forms, Notice of Hearing Rights (MHDDSD-OHP-0505-3/98), Notice of Grievance and Appeal Process (MHDDSD-OHP-0504-3/98), and Administrative Hearing Request forms (AFS 443) in all offices; and

(4) Assurance that Contractor and its Participating Providers will take no retaliatory action against the OHP Member for filing a Grievance or Appeal or requesting a DHS administrative hearing.

e. Deliver the Notice of Action by mail to OHP Member or OHP Member Representative.

f. Have a method of forwarding to the QA Committee of OMHAS, as necessary, an analysis of Grievances and Appeals received and DHS administrative hearings requested.

g. Retain the following documents regarding Grievances and Appeals and DHS administrative hearings in a central location:

(1) the log of Grievances and Appeals received and hearings requested;
(2) a file of written Grievances and Appeals received and hearings requested, records of the review or investigation, and resolution.
(3) files shall be maintained for a minimum of two calendar years from the date of resolution.

h. Afford OHP Members or OHP Member Representatives the full use of the Grievance and Appeals process and DHS administrative hearing procedures without penalty.

i. Cooperate with OMHAS and OHP Member or OHP Member Representative in seeking a remedy to the Grievance or Appeal and DHS administrative hearing issues and comply with and fully implement the hearing decision. Cooperation may include providing a written response to OMHAS upon request.

j. Cooperate in DHS administrative hearing process and make available, as determined necessary by OMHAS Representative prior to the hearing or the Hearing Officer during the hearing, all persons with relevant information and all pertinent files and Clinical Records.

4. Procedure for DHS Administrative Hearings

a. If the hearing issue involves a Notice of Action, or a decision about a Appeal, the OHP Member or OHP Member Representative must request a hearing within 45 calendar days of the date of the Notice of Action.

(1) If the hearing issue involves a Notice of Action that involved benefit continuation and the OHP Member or OHP Member Representative wishes to have benefits continued while the hearing issue is being resolved, the OHP Member or OHP Member Representative must request a hearing before the effective date of the intended action or within ten calendar days after the date of the Notice of Action or written Appeal decision was mailed or given to the OHP Member or OHP Member Representative.

(2) If the OHP Member or OHP Member Representative wishes to have the hearing dealt with in an expeditious manner, the OHP Member or OHP Member Representative must indicate such on the Administrative Hearing Request (form AFS 443) and explain why a decision is needed right away. The OHP Member is entitled to an expedited hearing if the mental status of the OHP Member meets the definition of an Emergency Situation or Urgent Situation and the situation cannot wait to be addressed within the time frames associated with a regular Hearing.

b. Upon receipt of the Administrative Hearings Request (form AFS 443), the receiver shall forward it and any documentation related to the hearing issue to OMHAS Representative and the Office of Administrative Hearings.

c. OMHAS Representative shall notify the Contractor within five (5) working days and shall review the Administrative Hearing Request, documentation related to the hearing issue, and computer records to determine whether the claimant or the person for whom the request is being made is an OHP Member; whether the hearing request was timely (requested within 45 calendar days of the Notice of Action, or a decision about an Appeal and whether benefit continuation has been requested.

(1) In cases where the OHP Member or OHP Member Representative wishes to have benefits continued while the hearing issue is being resolved, OMHAS Representative will notify the Contractor to continue the services. The service shall be continued until whichever of the following occurs first (but in no event should exceed ninety (90) days from the date of the OHP Member's or OHP Member Representative's request for a DHS administrative hearing):

(a) the current authorization expires; or
(b) decision is rendered about the Appeal; or
(c) the client is no longer eligible for Medicaid benefits.

The Contractor shall notify the OHP Member in writing that it is continuing the service and that if the hearing is resolved against the OHP Member, the cost of any services continued after the effective date of the Client Notice may be recovered from the OHP Member.

(2) If OMHAS Representative finds that the person for whom the request is being made is not an OHP Member or that the hearing request was untimely or that a request for benefit continuation was untimely, OMHAS Representative shall request the Office of Administrative Hearings to conduct a pre-hearing conference to determine whether there is jurisdiction to hear the case and/or whether the OHP Member or OHP Member Representative had Good Cause for making a late request.

(3) If the hearings officer finds that there is no jurisdiction to hear the case and/or that Good Cause did not exist, the hearings officer shall issue a proposed order notifying the claimant of the decision.

d. In those situations where there is jurisdiction and/or Good Cause as determined by the hearings officer during the brief hearing, the following shall occur.

(1) The hearings officer shall schedule a hearing on a day and time that is acceptable to OMHAS Representative and the OHP Member.

(2) Contractor Representative and OMHAS Representative shall collect relevant documentation and submit it for review by the clinical directors or designees of the clinical directors of payers with an interest in the hearing issue.

(3) The clinical directors or designees shall determine if the case was handled correctly and inform Contractor Representative or OMHAS Representative of the conclusion reached.

(4) If it is determined that the case was handled incorrectly, Contractor Representative or OMHAS Representative shall inform the OHP Member or OHP Member Representative of how the issue will be addressed. If the OHP Member or OHP Member Representative is satisfied with how the issue will be addressed, the OHP Member or OHP Member Representative shall notify, by phone and in writing, OMHAS Representative that the request for hearing is being withdrawn.

(5) If it is determined that the case was handled correctly and the original decision stands, or when the case was handled incorrectly and the OHP Member or OHP Member Representative is not satisfied with

how the issue will be addressed, Contractor Representative shall identify witnesses to testify during the hearing, prepare a letter stating the position of Contractor concerning the issue and forward copies of all evidence to OMHAS Representative.

(6) OMHAS Representative shall prepare a pre-hearing summary of findings and conclusions based on research efforts, review of documentation submitted and interviews with parties to the issue.

(7) OMHAS Representative shall offer to the OHP Member or OHP Member Representative a pre-hearing conference with DHS Hearings Officer and Contractor so that all parties with an interest in the hearing issue can explain facts and positions regarding the hearing issue.

(8) OMHAS Representative shall update the pre-hearing summary based on the pre-hearing conference, if held, and at least seven working days before the scheduled hearing forward copies of the hearing packet to the hearing officer or other designated representative, claimant and Contractor.

(9) The DHS Hearings Officer shall conduct the hearing in accordance with OAR 137-003-0501 through 137-003-0700. Following the conclusion of the hearing, the hearings officer will issue a proposed order. After considering any timely exceptions and argument, DHS will issue a final order in accordance with OAR 137-003-0665.

(10) The OHP Member or OHP Member Representative may request reconsideration of a final order or request a rehearing as described in OAR 137-003-0675, Reconsideration and Rehearing – Contested Cases.

5. Expedited Hearings

a. An OHP Member is entitled to an expedited administrative hearing if the mental status of the OHP Member meets the definition of an Emergency Situation or Urgent Situation and the situation cannot wait to be addressed within the time frames associated with a regular hearing. The OHP Member or OHP Member Representative must request an expedited hearing and provide information justifying such a request.

b. Upon receipt of an expedited DHS administrative hearing request, Contractor Representative or OMHAS Representative who received the request shall immediately notify other payers with an interest in the issue and begin collecting relevant documents.

c. Contractor Representative shall forward, as soon as available, information collected to OMHAS Representative. These documents shall include preauthorization documents, Notices of Action , and Clinical Records supporting the notice and degree of urgency of the issue.

d. Contractor Clinical Director and OMHAS Medical Director, or designees of said directors shall, within, as nearly as possible two (2) working days from date of request, review documentation received to determine if the mental status of the OHP Member meets the definition of Emergency Situation or Urgent Situation. Contractor Clinical Director and OMHAS Medical Director shall discuss their findings and attempt to come to agreement. If agreement cannot be reached, the decision of the OMHAS Medical Director shall be final.

e. Contractor Clinical Director and OMHAS Medical Director, or designees of said directors shall notify Contractor Representative and OMHAS Representative of the decision and the basis for that decision.

f. Contractor Representative or OMHAS Representative shall notify, by phone and in writing, the appropriate parties of the decision about whether the expedited request will be granted. If an expedited DHS administrative hearing was requested, both the OHP Member and the Office of Administrative Hearings will be notified.

SAMPLE NOTICE OF ACTION
MHO LETTERHEAD

Date of Notice

Name of Member
Street Address
City, State and Zip Code

Notice ID Number
Member ID Number
Practitioner Name

Proposed Treatment/ Condition

Dear *[Name of Member]*:

This is a notice that *[TYPE OF MENTAL HEALTH SERVICE]* will be *[REDUCED/SUSPENDED/TERMINATED]* on *[DATE]*. This *[TYPE OF TREATMENT]* is denied because of *[REASON FOR DENIAL]*.

If you disagree with this decision and you want to do something about it, you must do one or both of the following:

File an Appeal. You can file an Appeal. Information about how to file an Appeal is attached to this letter. If you file an Appeal, it must be filed within 30 calendar days of this letter.

Request a hearing. If you request a hearing, you must make the request within 45 calendar days of the date of this letter or, if you do the Appeal first, within 45 calendar days of the date of the Appeal decision. If you request a hearing, you will lose your right to use the Appeal process. Information about how to request a hearing is attached to this letter.

You can call *[NAME AND PHONE NUMBER OF MHO REPRESENTATIVE]* for more information.

IMPORTANT!

If you want your [TYPE OF TREATMENT] to stay the same while you wait for the Appeal or hearing decision, you must file your Appeal or request a hearing by [DATE OF ACTION] or within ten calendar days after the date this letter is mailed or given to you, whichever is later. You need to say on your Appeal form or hearing request form that you want your benefits/services to stay the same. If your benefits/services stay the same and you lose the Appeal or hearing, you may be required to pay for the cost of the benefits/services you received from the [DATE OF ACTION] until the decision.

OHP-0504 (Updated on 12/02)

NOTICE OF GRIEVANCE AND APPEAL PROCESS

❖Where to get an Grievance and Appeal form. Call the name and phone number of the mental health plan on your ID card for a Grievance and Appeal form. Also, you can call or ask your mental health provider for a form.

❖How to file the Grievance or. Fill out the form. Explain why you disagree with the decision. Tell what you want to happen. Sign the form. Send it or take it to the address listed on the form.

❖If you have an urgent problem. If you need a decision quickly you may ask for an Expedited Appeal process. You need to indicate in the place provided on the form that you are requesting an expedited process and write why you need to have your Grievance or Appeal decided right away. The medical director will look at your records and the reason you gave and decide if your Grievance or Appeal needs to be decided right away.

❖Deadlines for filing the Appeal. If your Appeal is about a decision in a written notice you received, you must file your Appeal within 30 calendar days of the date of the notice you received. You may be able to get more time if you have good cause for being late.

If your Grievance or Appeal is about a change in services/benefits and you want the services/benefits to stay the same while you wait for the decision, you must file by the date your services/benefits will change or within 10 calendar days after the date the letter notifying you of the change was mailed or given to you, whichever is later.

❖When a decision will be made. You will get a decision about your Grievance or Appeal within 20 calendar days of when your Grievance or Appeal was received.

❖If you do not agree with the decision, you can ask for a hearing. Information about how to request a hearing is attached to this letter. If you ask for a hearing before you get a decision, you lose the right to use the Grievance and Appeal process.

❖Grievance and Appeal records. Any information in the file can be used in the hearing if you request a hearing.

NOTICE OF HEARING RIGHTS

- Where to get a hearing request form. The form is called the Administrative Hearing Request (form AFS 443). You can get the form by calling the local Department of Human Services (DHS) office and asking for it. Also, you can get the form from your mental health provider or by calling the name and phone number of the Mental Health Plan on your I.D. card, or by calling the Office of Mental Health and Addiction Services at (503) 945-9449.

- How to file your request for a hearing. Fill out the hearing request form. Give the form to your provider or call the name and phone number on the attached letter for an address. You also may send the form directly to OMHAS Representative at Office of Mental Health and Addiction Services at, 2575 Bittern Street NE, P.O. Box 14250 Salem, OR 97309-0740.

- If you have an urgent problem. If you need a decision quickly, you may ask for an Expedited Hearing. You need to write on your request that it is an expedited request and why you think you need to have a decision right away. The OMHAS Medical Director will look at your records and the reason you gave and decide if you need a decision right away.

- Deadlines for filing your request for a hearing. If your hearing request is about a decision in a letter you received, you must file your hearing request within 45 calendar days of the date of the letter you received or within 45 calendar days of the date of the Complaint decision if you waited for a Complaint decision. You may be able to get more time if you have good cause for being late.

  If your hearing request is about a change in services/benefits and you want the services/benefits to stay the same while you wait for the hearing decision, you must file a hearing request by the date your services/benefits will change or within 10 calendar days after the date the attached letter was mailed or given to you, whichever is later. If you waited for a Complaint decision and you want the services/benefits to stay the same while you wait for a hearing decision, you must file the hearing request within 10 calendar days of the date the Complaint decision was mailed or given to you, whichever is later.

- What will happen. OMHAS Representative will ask you what you think was wrong. You have a right to a pre-hearing conference with OMHAS Representative. You may be able to resolve the problem without a hearing. If the problem is not resolved, you will have a hearing. At a hearing, you can tell the DHS Hearing Officer your position and you can have other people testify for you. The State of Oregon will be represented and can have people testify. The Hearing Officer will issue proposed

order and DHS will make a final decision within 90 days from the date of your request for a hearing.

- If you disagree with the decision. You can request a reconsideration or appeal to the Court of Appeals if you disagree with the decision.

- Who can help. You can have a lawyer or someone else help you at the hearing. The state will not pay for a lawyer. Your local legal aid office or Oregon Advocacy Center (1-800-452-1694) may be able to give you advice or help you with your hearing.

- When a decision will be made. DHS must make a decision within 90 days of your request for a hearing.

EXHIBIT H.1
PROCEDURE FOR LONG TERM PSYCHIATRIC CARE DETERMINATIONS FOR OHP MEMBERS AGE 18 TO 64.

ACTOR	ACTION
Contractor	1. Determines whether the situation of the OHP Member meets both of the following criteria: a. There is a need for either Intensive Psychiatric Rehabilitation or other Tertiary Treatment in an Oregon State Hospital or Extended Care Program, or Extended and Specialized Medication Adjustment (psychotropic) in a secure or otherwise highly supervised environment; and b. The OHP Member has received all Usual and Customary Treatment including, if Medically Appropriate, establishment of a Medication program and use of a Medication Override Procedure. 2. If the situation of the OHP Member meets both criteria listed above in step 1, does the following with assistance from Acute Inpatient Hospital Psychiatric Care or Subacute Psychiatric Care or Other Inpatient Services staff: a. Contacts the OMHAS ECMU Screener at (503) 945-2997 or (503) 945-2998, during normal business hours (Monday through Friday, 8 a.m. to 5 p.m.).

b. Completes a Request for Long Term Psychiatric Care Determination for Persons Age 18 to 64 (request form).

c. Obtains the following documents:

(1) Physician's history and physical;

(2) Current Medications, dosages, and length of time on Medication;

(3) Reports of other consultations;

(4) Social histories; and

(5) Current week's progress notes.

ECMU Screener

3. Sends, by facsimile, the request form and supporting documents to the OMHAS ECMU Screener at (503) 945-0947.

4. Within three working days of receiving a completed request form, does the following:

a. Reviews the request form and documentation for compliance with criteria for LTPC with the following facilities:

(1) OSH, Portland Campus;

(2) OSH, Salem Campus;

(3) Eastern Oregon Psychiatric Center (EOPC);

(4) Efficacious alternatives in the community.

ECMU Screener (Cont.)		b. If necessary, visits the Acute Inpatient Hospital Psychiatric Care or Subacute Psychiatric Care or Other Inpatient Services facility to interview staff and the OMAP Member. c. Indicates findings, determination and transfer date, if applicable, on the request form. d. Discuss findings, determination and placement alternatives with the Contractor.
	5.	Sends, by facsimile, the completed request form to Contractor. If the OHP Member is enrolled with Greater Oregon Behavioral Health, Inc. (GOBHI), also forwards a copy of the request form to DHS Seniors and People with Disabilities Program and the EOPC billings office.
Contractor	6.	If the OHP Member is not found Appropriate for LTPC or found Appropriate for LTPC but on a date other than that specified in Section V.B.3.i.(3)(a) of this Agreement, does the following: a. Decides whether to accept decision of the ECMU Screener. b. If the decision is not accepted, then requests a clinical review within three working days of receiving notice of the LTPC determination. Sends a written request and documentation submitted in accordance with Step 2.c. of this Exhibit to the Office of Mental Health and Addiction Services (OMHAS) via facsimile at (503) 947-1023.

		c. If the decision is accepted, either provides Appropriate treatment or initiates transfer of the OHP Member to the setting recommended as of the date specified.
OMHAS	7.	If the Contractor requests a clinical review, sends, by facsimile, the request form and documentation submitted by the Contractor in accordance with Step 2.c. of this Exhibit to the Clinical Reviewer.
Clinical Reviewer	8.	Does the following within three working days of receiving the clinical review packet: a. Reviews all documentation submitted by the Contractor in accordance with Step 2.c. of this Exhibit. b. Decides whether the OHP Member is Appropriate for LTPC. c. Determines the effective date of LTPC as specified in Section V.B.3.i.(3) of this Agreement, if applicable. d. Updates the request form. e. Notifies, by phone, the Contractor, OMHAS and the ECMU Screener of the determination. f. Sends, by facsimile, the completed request form to the Contractor, OMHAS and the ECMU Screener.

ECMU Screener	9.	If the OHP Member is found Appropriate for LTPC, coordinates with the physician and admission staff the transfer to the setting recommended as of the date specified.
OMHAS	10.	If transfer to the LTPC setting will not occur on the date the OHP Member is Appropriate for LTPC, DHS will assume payment responsibility for charges related to the Acute Inpatient Hospital Psychiatric or Other Inpatient Services stay from the effective date of LTPC until the OHP Member is discharged from such setting.

DETERMINATION			
Patient's Name:			Prime No.:
❑ Approved	Referral Date:	Name of Clinical Decision Maker:	
❑ Denied	Approval Date:	Date of Determination:	
		Date Patient Admitted to State Hospital:	

CRITERIA FOR LONG TERM PSYCHIATRIC INPATIENT CARE

- ❑ Primary DSM Diagnosis is severe psychiatric disorder
- ❑ Documented need for 24-hour hospital level medical supervision
- ❑ At least one of the following conditions is met:
  - ❑ Need for extended (more than 21 days) regulation of Medications due to significant complications arising from severe side effects of Medications.
  - ❑ Need for continued treatment with electroconvulsive therapy where an extended (more than 21 days) inpatient environment is indicated and the inappropriateness of a short-term or less restrictive treatment program is documented in the Clinical Record.
  - ❑ Continued actual danger to self, others or property that is manifested by at least one of the following:
    - ❑ The OHP Member has continued to make suicide attempts or substantial (life-threatening) suicidal gestures or has expressed continuous and substantial suicidal planning or substantial ongoing threats.
    - ❑ The OHP Member has continued to show evidence of danger to others as demonstrated by continued violent acts to person or imminent plans to harm another person.
    - ❑ The OHP Member has continued to show evidence of severe inability to care for basic needs but has potential for significant improvement with treatment.
  - ❑ Failure of intensive extended care services evidenced by documentation in the Clinical Record of:
    - ❑ An intensification of symptoms and/or behavior management problems beyond the capacity of the extended care service to manage within its programs; and
    - ❑ Multiple attempts to manage symptom intensification or behavior management problems within the local Acute Inpatient Hospital Psychiatric Care unit.
- ❑ Has received all Usual and Customary Treatment including, if Medically Appropriate, establishment of a Medication program and use of a Medication Override Procedure.

OUTCOME OF CLINICAL REVIEW		
❑ Upheld	Transfer Date:	Name of Clinical Reviewer:
❑ Reversed		Date of Decision:

REQUEST FOR LONG TERM PSYCHIATRIC CARE DETERMINATION FOR PERSONS AGES 18 TO 64

<table>
<tr><td colspan="4">REQUEST</td></tr>
<tr><td colspan="3">Mental Health Organization: Referral Date:</td><td></td></tr>
<tr><td colspan="3">OHP Member Name:</td><td>DOB:</td></tr>
<tr><td colspan="2">Prime No (Required):</td><td>DSM
Axis I</td><td>DSM
Axis II</td><td>DSM
Axis III</td></tr>
<tr><td rowspan="3">Admission Date:</td><td rowspan="3">Proposed Transfer Date:</td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td colspan="4">BASIS FOR REQUEST (NOTE: All documents must be attached.)</td></tr>
<tr><td colspan="4">❑ There is a need for either:
❑ Intensive Psychiatric Rehabilitation or other Tertiary Treatment in an Oregon State Hospital or Extended Care Program, or
❑ Extended and Specialized Medication Adjustment (psychotropic) in a secure or otherwise highly supervised environment; and
❑ The OHP Member has received all Usual and Customary Treatment including, if Medically Appropriate, establishment of a Medication program and use of a Medication Override Procedure.</td></tr>
<tr><td colspan="4">DOCUMENTATION SUPPORTING REQUEST (NOTE: All documents must be attached.)</td></tr>
<tr><td colspan="4">❑ Physician's history and physical
❑ List of current Medications, dosages and length of time on Medication
❑ Reports of other Consultations
❑ Social histories
❑ Current week's progress notes</td></tr>
<tr><td colspan="4">ANALYSIS OF DOCUMENTATION SUPPORTING REQUEST</td></tr>
<tr><td colspan="4"></td></tr>
</table>

Update 10/02

EXHIBIT H.2
PROCEDURE FOR LONG TERM PSYCHIATRIC CARE DETERMINATIONS FOR OHP MEMBERS UNDER AGE 18

ACTOR	ACTION
Contractor	1. If the length of stay might exceed Usual and Customary Treatment, consults with one of the following regarding a potential need for LTPC: a. For OHP Members age 14 and under, the OMHAS Secure Children's Inpatient Program (SCIP) Representative; b. For OHP Members age 15 though 18, the Oregon State Hospital (OSH), Child and Adolescent Treatment Program (CATP), Community Outreach Team (COT) Representative. 2. Determines whether the situation of the OHP Member meets the criteria listed in step 5.a. 3. If the situation of the OHP Member meets such criteria, does the following with assistance from Acute Inpatient Hospital Psychiatric Care or Psychiatric Residential Treatment Services (PRTS) staff: a. For OHP Members age 14 and under, contacts the OMHAS SCIP Representative at (503) 947-4220, during normal business hours (Monday through Friday, 8:00 a.m. to 5:00 p.m.), or b. For OHP Members age 15 through 18, contacts the Oregon State Hospital (OSH), Child and Adolescent Treatment Program (CATP), COT Representative at (503) 945-7134 or (503) 945-7135, during normal business hours (Monday through Friday, 8 a.m. to 5 p.m.).

ACTOR	ACTION
	c. Completes a Request for Long Term Psychiatric Care Determination for Persons Under Age 18 (request form). d. Obtains the following documents: (1) Physician's history and physical; (2) List of current Medications, dosages, and length of time on Medication; (3) Reports of other Consultations; (4) Current psychosocial assessment; (5) Current week's progress notes; (6) Current Child Acuity of Psychiatric Illness (CAPI) score, if available; (7) Current psychological assessment; if determined medically appropriate ; (8) Current psychiatric assessment; (9) Psychiatric care admission history; and (10) Completed consent for release of information from the most recent residential or PRTS facility in which the child resided. 4. Sends, by facsimile, the request form and supporting documents to one the following: a. For OHP Members age 14 and under, the OMHAS Representative at (503) 947-4220, or b. For OHP Members Age 15 through 18, the OSH (COT) Representative at (503) 945-2807.

NOTE: Steps 5 through 11 are completed within seven working days of receiving a completed request form.

OMHAS Representative or COT Representative

5. Does the following:

a. Completes an initial screening to decide whether the Community Coordinating Committee (CCC) LTPC screening criteria is met. Such criteria includes the following:

(1) The primary DSM Axis I Diagnosis is from the OHP prioritized list of health services;

(2) There is documented evidence that the child has not responded to all Usual and Customary Treatment in an Acute Inpatient Hospital Psychiatric Care setting or PRTS level of care; and

(3) There is documented evidence that the child's psychiatric symptoms have intensified beyond the capacity of the Acute Inpatient Hospital or PRTS level of care; or

(4) In exceptional circumstances a child may be screened who is not currently in an Acute Care Hospital or current functioning and documentation of prior treatment and treatment oriented placements indicate placement into Acute Care of Psychiatric Residential Treatment will benefit the child;

(5) There is a documented need for 24-hour hospital level medical supervision under the direction of a psychiatrist in order to effectively treat the primary diagnosis; and

	(6) The current CAPI score indicates a level of acuity that requires inpatient care.
	b. If necessary, visits the Acute Inpatient Hospital Psychiatric Care or PRTS facility to interview staff and the OMAP Member.
	c. If CCC LTPC screening criteria is met, forwards the request form and supporting documentation to the CCC Chairperson and allocates time to attend the CCC LTPC screening.
	d. If CCC LTPC screening criteria is not met, notifies Contractor and CCC Chairperson.
CCC Chairperson	6. Schedules a CCC LTPC screening in conjunction with either the OMHAS SCIP Representative or the COT Representative.
	7. Collects and distributes documentation necessary for the CCC LTPC screening
	8. Invites the CCC LTPC screening persons who possess information needed to make the LTPC determination and develop the CCC Care Path Plan. Such persons may include Contractor, family members of the OMAP Member or legal guardian, and/or treatment providers.
CCC	9. Conducts the CCC LTPC screening.
	a. Determine whether admission criteria has been met.
CCC	b. Identifies efficacious community placement alternatives.

c. Discusses findings, alternatives and determination with the Contractor and either the OMHAS SCIP Representative or the OSH COT Representative.

d. Notes the final determination.

e. If admission criteria are met, does the following:

(1) Establishes an admission date and time; and

(2) Develops a CCC Care Path Plan.

f. If admission criteria are not met, determines an appropriate plan of care.

g. Completes the CCC LTPC Determination for Persons Under Age 18 form by indicating findings, determination and planned admission date, if applicable.

10. If the OMAP Member is found Appropriate for LTPC, sets the effective date of LTPC as specified in Section V.B.3.i.(3)(a) of this Agreement.

11. Sends, by facsimile, the completed CCC LTPC Determination for Persons Under Age 18 form to Contractor. Sends a copy to Institutional Revenue Section of DHS.

Contractor

12. If the OHP Member is not found Appropriate for LTPC or found Appropriate on a date other than the date described in step 10, does the following:

a. Decides whether to accept the decision.

b. If the decision is not accepted, requests a

	clinical review within three working days of receiving notice of the screening decision. Sends a written request and documentation submitted in accordance with Step 3.c. of this Exhibit to OMHAS, Child and Adolescent Services Section via facsimile at (503) 947-1023.
	c. If the decision is accepted, either provides Appropriate Treatment or initiates transfer of the OHP Member to the setting recommended as of the date specified.
OMHAS	13. If a clinical review is requested, send, by facsimile, the request form and documentation submitted by Contractor in accordance with Step 3.c. of this Exhibit to the Clinical Reviewer.
Clinical Reviewer	14. Does the following within five working days of receiving the clinical review packet:
	a. Reviews all forms and documentation submitted by Contractor in accordance with Step 3.c. of this Exhibit.
	b. Decides whether the OHP Member is Appropriate for LTPC.
	c. Determines the effective date of LTPC as specified in V.B.3.i.(3)(a) of this Agreement, if applicable.
	d. Updates the CCC LTPC Determination form.
	e. Notifies by phone, Contractor, OMHAS SCIP Representative or OSH COT Representative of the determination.

	f. Sends, by facsimile, the completed CCC LTPC Determination form to Contractor, OMHAS SCIP Representative or OSH COT Representative Contractor.
OMHAS	15. If transfer to OSH CATS will not occur on the date the OHP Member is Appropriate for LTPC, DHS assumes payment responsibility for charges related to the Acute Inpatient Hospital Psychiatric stay from the effective date of LTPC until the OHP Member is discharged from such setting.

REQUEST FOR LONG TERM PSYCHIATRIC CARE DETERMINATION FOR PERSONS UNDER AGE 18

REQUEST	
Child's Name:	Referral Date:
Parent/Guardian:	
Address:	Phone:
City:	County:
Child's Medicaid Prime No:	Child's SS#:
Mental Health Organization:	DOB:
Current Program:	Admission Date:

PRIMARY DSM DIAGNOSIS	
Axis I Diagnosis:	Code:
Axis II Diagnosis:	Code:
Axis III Diagnosis:	Code:
Axis IV Diagnosis:	Code:
Axis V Diagnosis:	Code:

DOCUMENTATION SUPPORTING REQUEST (NOTE: All documents must be attached.)

- ❑ Physician history and physical
- ❑ List of current medications, dosages, and length of time on medication
- ❑ Reports of other consultations
- ❑ Current psychosocial assessment
- ❑ Current week's progress notes
- ❑ Current Child Acuity of Psychiatric Illness (CAPI) score (if available)
- ❑ Current psychological assessment (if medically appropriate)
- ❑ Completed consent for release of information from the most recent residential or PRTS facility in which the child resided
- ❑ Current psychiatric assessment
- ❑ Psychiatric care admission history

SUMMARY OF REASONS FOR REQUEST

Long-Term Psychiatric Care Determination for Persons Under Age 18
Child's Name:
Mental Health Organization:
Name of OMHAS SCIP or COT Representative:
Name of CCC Chairperson:
CRITERIA FOR LONG TERM PSYCHIATRIC INPATIENT CARE (NOTE: Must meet all criteria.)
❑ Primary DSM Axis I diagnosis is from the OHP prioritized list ❑ Documented evidence that the child has not responded to all Usual and Customary Treatment in an acute inpatient hospital psychiatric care or PRTS level of care setting ❑ Documented evidence that the child's psychiatric symptoms have intensified beyond the capacity of the acute inpatient hospital psychiatric care or PRTS level

of care setting ❑ Documented need of 24-hour hospital level medical supervision under the direction of a psychiatrist in order to effectively treat the primary diagnosis ❑ Current CAPI score indicates a level of acuity that requires inpatient psychiatric care

Outcome of CCC Clinical Screening

❑ Upheld ❑ Reversed	Planned Admission Date:	Name of Clinical Reviewer: Date of Decision:

Signature of OMHAS SCIP Representative or COT Representative:	Date:

Update 10/02

Community Coordinating Committee
Care Path Plan

Child's Name:
DISCHARGE PLAN AND CRITERIA
If Long-Term Psychiatric Care admission criteria are met, include a written plan for discharge to the least restrictive appropriate setting with specific discharge criteria linked to resolution of symptoms and behaviors that justified admission.
SERVICES RECOMMENDED
If Long-Term Psychiatric Care admission criteria are not met, describe services that are recommended.
Signature of CCC Chairperson Date:

Update 10/02

EXHIBIT H.3
PROCEDURE FOR LONG TERM PSYCHIATRIC CARE DETERMINATION FOR OHP MEMBERS REQUIRING GEROPSYCHIATRIC TREATMENT

ACTOR	ACTION
Contractor	1. Determines whether the situation of the OHP Member meets both of the following criteria: a. There is a need for either Intensive Psychiatric Rehabilitation or other Tertiary Treatment in an Oregon State Hospital (or for adults Extended Care Program), or Extended and Specialized Medication Adjustment (psychotropic) in a secure or otherwise highly supervised environment; and b. The OHP Member has received all Usual and Customary Treatment including, if Medically Appropriate, establishment of a Medication program and use of a Medication Override Procedure. 2. If the situation of the OHP Member meets both of the criteria listed in step 1, determines whether the OHP Member is eligible for Geropsychiatric Treatment Services. To be eligible for these services, the OMAP Member must be: a. Age 65 or over, or b. Ages 18 to 64 and have significant nursing care needs (e.g., must be bathed, dressed, groomed, fed, and toileted by staff) due to an Axis III disorder of an enduring nature.
Contractor	3. With the assistance of Acute Inpatient Hospital Psychiatric Care or Subacute Psychiatric Care or

ACTOR	ACTION
	Other Inpatient Services staff, does the following:
	a. Contacts the OSH Geropsychiatric Outreach and Consultation Service (OCS) at (503) 945-7136, Monday through Friday, 8:00 a.m. to 5:00 p.m.;
	b. Obtains the Request for Long-Term Care Determination for Persons Requiring Geropsychiatric Treatment (request form) from the OSH Geropsychiatric OCS staff;
	c. Assess OHP Member's capacity to provide informed consent. If OHP Member is determined unable to provide informed consent, take appropriate action towards civil commitment for OHP Members not already protected by guardianship.
	d. Obtains all supporting documents listed on the request form.
	4. Sends, by facsimile, the request form and documents to the OSH Geropsychiatric OCS Screener at (503) 945-2807.
OCS Screener	5. Within three working days of receiving a completed request form, does the following:
	a. Reviews the request form and documentation for compliance with criteria for LTPC for persons requiring geropsychiatric treatment.
OCS Screener	b. If necessary, visits the Acute Inpatient Hospital Psychiatric Care or Subacute Psychiatric Care or Other Inpatient Services facility to interview staff and the

ACTOR	ACTION
	OHP Member. c. Discusses findings, determination, and placement alternatives with Contractor or Contractor Representative (i.e., the person who sent the request form or other person designated on the request form). d. Indicates findings, determination, and effective date of LTPC as specified in Section V.B.3.i.(3)(c) of this Agreement on the request form.
	6. If the OHP Member is found Appropriate for LTPC at OSH-GTS, works with OSH-GTS, Contractor, and the Acute Inpatient Hospital Psychiatric Care or Subacute Psychiatric Care or Other Inpatient Services facility to set the OSH-GTS admission date and to coordinate such admission.
OCS Screener	7. Sends, by facsimile, the completed request form to Contractor and requester. Also, forwards a copy of the request form to the Institutional Revenue Section of DHS.
Contractor	8. If the OHP Member is not found Appropriate for LTPC at OSH-GTS, or is found Appropriate on a date other than the date specified in step 5.d., does one of the following: a. Accepts the decision of the OCS Screener and provides Appropriate Treatment. Works with Acute Inpatient Hospital Psychiatric Care or Subacute Psychiatric Care or Other Inpatient Services staff, Senior and Disabled Services DHS staff, and in some cases, Enhanced Care Services staff to develop a plan for continued care and Treatment.

ACTOR	ACTION
	b. If the decision is not accepted, requests a clinical review within three working days of receiving notice of the LTPC determination. Sends a written request and documentation specified in Step 3.d. of this Exhibit to the OMHAS via facsimile at (503) 947-1023.
OMHAS	9. If Contractor requests a clinical review, sends, by facsimile, the request form and documentation submitted by Contractor in accordance with Step 3.d. of this Exhibit to the Clinical Reviewer.
Clinical Reviewer	10. Does the following within three working days of receiving the clinical review packet: a. Reviews all documentation submitted by Contractor in accordance with Step 3.d. of this Exhibit. b. Decides whether the OHP Member is Appropriate for LTPC. c. Determines the effective date of LTPC as specified in Section V.B.3.i.(3) of this Agreement, if applicable. d. Updates the request form. e. Notifies by phone: Contractor, OMHAS and the OCS Screener of the determination. f. Sends, by facsimile, the completed request form to Contractor, OMHAS and the OCS Screener.

ACTOR	ACTION
OCS Screener	11. If the OHP Member is found Appropriate for LTPC, coordinates with the physician and admission staff the transfer to the setting recommended as of the date specified.
OMHAS	12. If transfer to the LTPC setting will not occur on the effective date of LTPC, DHS assumes payment responsibility for charges related to the Acute Inpatient Hospital Psychiatric or Other Inpatient Services stay from the effective date of LTPC until the OHP Member is discharged from such setting.

Request for Long-Term PsychiatricCare Determination for Persons Requiring Geropsychiatric Treatment

REQUEST				
Mental Health Organization:			Referral Date:	
OHP Member Name:				DOB:
Referral Agent:		**DSM Axis I**	**DSM Axis II**	**DSM Axis III**
Admission Date:	Prime Number:			

BASIS FOR REQUEST (NOTE: All criteria must be met.)

- ❑ OHP Member is 65 or older or OHP Member is 64 or younger AND has significant nursing care needs (e.g., must be fed, dressed, groomed, bathed, and toileted by staff) AND these needs arise from an Axis III disorder of an enduring nature (e.g., Alzheimer's, Huntington's, TBI, CVA)
  (Note: A person 64 or under whose nursing care needs arise from acute decompensation of an Axis I disorder or are the result of behavioral noncompliance would not be admitted to GTS and should be referred to ECMU.)
- ❑ There is a need for either:
  - ❑ Intensive Psychiatric Rehabilitation or other Tertiary Treatment in an Oregon State Hospital or Extended Care Program, or
  - ❑ Extended and Specialized Medication Adjustment (psychotropic) in a secure or otherwise highly supervised environment; and
- ❑ The OHP Member has received all Usual and Customary Treatment, including if Medically Appropriate, establishment of a Medication program and use of a Medication Override Procedure.

DOCUMENTATION SUPPORTING REQUEST
(NOTE: All documents must be attached and must document the basis for request criteria.)

- ❑ Physician's history and physical
- ❑ List of current Medications, dosages and length of time on Medication
- ❑ Reports of other Consultations
- ❑ Social histories
- ❑ Current week's progress notes
- ❑ Diagnostic Test results and Lab reports
- ❑ Guardianship or civil commitment documents (if applicable
- ❑ Civil Commitment investigation report (if available)
- ❑ ADL Assessment (if available)
- ❑ Advance Directive (if available)

Please summarize the reason why the patient needs Long-Term Psychiatric Care.

ANALYSIS OF DOCUMENTATION SUPPORTING REQUEST
(Remainder of form to be completed by Gero Outreach staff.)

DETERMINATION

Patient's Name:		Prime No.:
❑ Approved	Date of Determination:	Name of Clinical Decision Maker:
❑ Denied		Date Patient Admitted to OSH-GTS:

CRITERIA FOR LONG TERM GEROPSYCHIATRIC INPATIENT CARE

- ❑ Person is 65 or older or person is 64 or under and meets nursing care criteria.
- ❑ Person has a psychiatric/neurological disorder causing severe behavioral disturbances with need for 24 hour hospital level medical supervision.
- ❑ At least one of the following conditions is met:
  - ❑ Need for extended (more than 21 days) regulation of Medications due to significant complications arising from severe side effects of Medications.
  - ❑ Need for continued Treatment with electroconvulsive therapy where an extended (more than 21 days) inpatient environment is indicated and the inappropriateness of a short-term or less restrictive treatment program is documented in the Clinical Record.

- ❑ Continued actual danger to self, others or property that is manifested by at least one of the following:
  - ❑ The OHP Member has continued to make suicide attempts or substantial life-threatening behavior or has expressed continuous and substantial suicidal planning or substantial ongoing threats.
  - ❑ The OHP Member has continued to show evidence of danger to others as demonstrated by continued destructive acts to person or imminent plans to harm another person.
  - ❑ For OHP Members 65 and over ONLY: The OHP Member has continued to show evidence of severe inability to care for basic needs due to significant decompensation of an Axis I diagnosis.
- ❑ Failure of intensive Enhanced Care Services evidenced by documentation in the Clinical Record of:
  - ❑ An intensification of symptoms and/or behavior management problems beyond the capacity of the Enhanced Care Service to manage within its programs; and
  - ❑ A minimum of one attempt to manage symptom intensification or behavior management problems within the local Acute Inpatient Hospital Psychiatric Care unit.
  - ❑ Has received all Usual and Customary Treatment including, if Medically Appropriate, establishment of a Medication program and use of a Medication Override Procedure. Has received medical evaluation and stabilization of acute medical problems.

OUTCOME OF CLINICAL REVIEW

❑ Upheld	Transfer Date:	Name of Clinical Reviewer:
❑ Reversed		Date of Decision:

Update 10/02

EXHIBIT I
PRACTITIONER INCENTIVE PLANS

1. Contractor shall comply with all requirements of this Exhibit to ensure compliance with Sections 4204(a) and 4731 of the Omnibus Budget Reconciliation Act of 1990 that concern practitioner incentive plans. The purpose of this Act is to ensure that OHP Members are not being denied access to Medically Appropriate referral services based on financial incentives. Contractor shall not set into place any financial incentives which reduce or limit provision of Covered Services to OHP Members as specified in this Agreement.

2. Contractor shall complete and submit to OMHAS Report I 1: Practitioner Incentive Plan Disclosure, under the following circumstances:

   a. On the effective date of this Agreement;

   b. At least 45 calendar days before the effective date of changes to the referral incentive arrangements which results in a change in the amount of risk or Stop Loss Protection or a change in the risk formula to include coverage of services not provided by the practitioner or practitioner group which were not previously included in the formula;

   c. Within 30 calendar days of OMHAS request; and

   d. On the effective date of any amendment to this Agreement that extends Contractor's Service Area.

3. Contractor shall provide to any OHP Member who requests it the following information:

   a. Whether the Contractor uses a practitioner incentive plan that affects the use of referral services;

   b. The type of incentive arrangement;

   c. Whether Stop Loss Protection is provided; and

   d. If a survey is required to ensure access to services is not being denied based on the practitioner incentive plan, a summary of the survey results.

4. If Contractor practitioner incentive plans meet the definition appearing in Report I 1: Practitioner Incentive Plan Disclosure, Contractor shall complete and submit to OMHAS, on the effective date of this Agreement and at least 45 calendar days before the effective date of changes to the practitioner incentive plans, Report I 2: Practitioner Incentive Plan Detail. OMHAS shall use information reported to determine whether Contractor incentive arrangements place the practitioner or practitioner group at risk for amounts beyond a specified risk threshold.

   a. Risk threshold means the maximum risk to which a practitioner or practitioner group may be exposed under a practitioner incentive plan without being at substantial financial risk. It applies to incentive arrangements involving referral services. The specified risk threshold is set at 25 percent of potential earnings of the practitioner or practitioner group.

   b. Substantial financial risk applies to those practitioners and practitioner groups with a patient panel size of less than 25,001 OHP Members or a patient panel size of more than 25,000 OHP Members as a result of pooling OHP Members. A substantial financial risk exists for these practitioners and practitioner groups if the incentive arrangement described above in 4.a. places the practitioner or practitioner group at risk of losing more than the risk threshold.

   c. An incentive arrangement shall be determined as causing substantial financial risk under the following circumstances:

      (1) Withholds are greater than 25 percent of the maximum anticipated total incentive payments (salary, Fee-For-Service payments, Capitation Payments, returned withhold and bonuses);

      (2) Withholds less than 25 percent of potential payments if the practitioner or practitioner group is potentially liable for amounts exceeding 25 percent of potential payments;

      (3) Bonus that is greater than 33 percent of potential payments minus the bonus;

      (4) Withholds plus bonuses if this sum equals more than 25 percent of potential payments. The threshold bonus percentage for a particular withhold percentage may be calculated using the formula:

      withhold percentage - 0.75(bonus percentage)+25%

(5) For Capitation arrangements, if the difference between the maximum possible payments and minimum possible payments is more than 25 percent of the maximum possible payments; or the maximum and minimum possible payments are not clearly explained in the practitioner's or practitioner group's contract; and

(6) Any other incentive arrangements that have the potential to hold a practitioner or practitioner group liable for more than 25 percent of potential payments.

5. If Contractor is found to have referral incentive arrangements which place its practitioners or practitioner groups at substantial financial risk, Contractor shall conduct a survey of OHP Members to address satisfaction with the quality of services provided and degree of access to the services. Such survey may be conducted as part of survey administration occurring based on Contractor's QA Program. Contractor shall provide OMHAS with survey data and results within 60 calendar days of the survey due date. The survey shall:

   a. Include either all current OHP Members of Contractor and those who have disenrolled for reasons other than loss of eligibility or relocation outside the service Areas; or all those OHP Members enrolled during the past twelve months or a sample of these OHP Members;

   b. Be designed, implemented and analyzed in accordance with commonly accepted principles of survey design and statistical analysis;

   c. Address the satisfaction of OHP Members and disenrolled OHP Members with the quality of services provided and their degree of access to the services; and

   d. Be conducted no later than one year after the effective date of the incentive arrangement and at least every two years thereafter .

6. Contractor shall ensure that all practitioners and practitioner groups determined to be at substantial financial risk have either aggregate or per OHP Member Stop Loss Protection in accordance with the following requirements:

   a. If aggregate Stop Loss Protection is provided, Contractor shall cover 90 percent of referral service costs (beyond allocated amounts) that exceed 25 percent of potential earnings of the practitioner or practitioner group; or

   b. If per patient Stop Loss Protection is provided, Contractor shall provide Stop Loss Coverage based on patient panel size as reflected in the following table:

Patient Panel Size	Per Patient Stop Loss Limit
Less than 1,000	$10,000
1,000 to 10,000	$30,000
10,001 to 25,001	$200,000
More than 25,000 (No Pooling)	No specification
More than 25,000 (Pooling)	$200,000

7. CMS may impose a penalty of up to $25,000 in addition to or in lieu of other remedies available under law if CMS determines that the Contractor either misrepresented or falsified information furnished to OMHAS or an OHP Member in regard to the Practitioner Incentive Plan provisions or failed to comply with the Practitioner Incentive Plan provisions specified in this Agreement.

8. DHS shall suspend payment for new OHP Members until it is satisfied that the basis for the determination by CMS is not likely to recur.

REPORT I 1:
PRACTITIONER INCENTIVE PLAN DISCLOSURE

Mental Health Organization:_____ Date Prepared:_____

Signature and Title of Authorized Representative:_____

Practitioner Incentive Plan: Any incentive arrangement between an eligible organization and a practitioner or practitioner group that may directly or indirectly have the effect of reducing or limiting Covered Services furnished with respect to individuals enrolled in the organization. The compensation arrangement may include a variety of payment methods that create financial incentives to influence the use of referral services which are arranged, but not directly provided, by the practitioner subject to the practitioner incentive plan. Such incentive arrangements may hold a practitioner or a practitioner group at risk for all or a portion of the cost of referral services and may provide additional compensation to the practitioner or practitioner group if the practitioner or practitioner group is successful at controlling the level of referral services.

QUESTION OR REQUIREMENT	RESPONSE
1. Does said organization use practitioner incentive plans as defined above for work performed under this Agreement?	
2. If the answer to item 1 is yes, answer these additional questions.	
a. Does the plan reference services that are not provided by the practitioner or practitioner group?	
b. Does the plan involve a withhold and/or bonus? If yes, what is the percent or dollar amount of the withhold and/or bonus?	
c. Does the plan require Stop Loss Protection? If yes, what type of stop loss is required? If yes, what amount of protection is required?	

<table>
<tr><td>d. What is the patient panel size?</td><td colspan="2"></td></tr>
<tr><td>If the panel size is based on a pooling of patients, describe the pooling method used.</td><td colspan="2"></td></tr>
<tr><td>e. Does the plan involve Capitation of practitioners or groups?</td><td colspan="2"></td></tr>
<tr><td rowspan="6">If yes, complete the table to the right using information from the most recent year.</td><td>Practitioner Type</td><td>Percent of Total Capitation Paid</td></tr>
<tr><td>Primary Care Practitioners</td><td></td></tr>
<tr><td>Referral Services to Specialists</td><td></td></tr>
<tr><td>Hospital</td><td></td></tr>
<tr><td>Other Types of Providers Services</td><td></td></tr>
<tr><td>Total</td><td></td></tr>
<tr><td>f. Does said organization conduct surveys of OHP Members to measure the impact of practitioner incentive plans on quality of services and access to services?</td><td colspan="2"></td></tr>
<tr><td>If yes, when was the last survey conducted and who was surveyed?</td><td colspan="2"></td></tr>
<tr><td>If yes, when will the next survey be conducted and who will be surveyed?</td><td colspan="2"></td></tr>
</table>

If yes, describe how the survey was designed, implemented and analyzed.	

DHS-OHP-0510-3/98

REPORT I 2: PRACTITIONER INCENTIVE PLAN DETAIL

Mental Health Organization:_____Date Prepared:_____

Provider Type	Patient Panel Size	Service Payments				Incentives					Total Service Payments and Incentives	Practitioner Liability
		Salary	Fee-for-Service	Capitation	Total	Bonus	Capitation Withhold	FFS Withhold	Referral Withhold	Total		
Primary Care Practitioners												
Referral Services to Specialists												
Hospital												
Other Types of Providers Services												
Total												

MHDDSD-OHP-0511-3/98

Instructions:

1. Provide the total aggregate amount of payment made by Contractor to each provider type by service payment and incentive arrangement for services delivered under this Agreement during the risk/incentive period.

2. If any one particular referral provider comprises 25% or more of any referral incentive arrangement, then provide the name, address and phone number of the provider group.

3. Provide a written, signed and dated statement and justification if any of the above information is to be considered confidential.

I 2: Practitioner Incentive Plan Detail

Bonus: A payment made to a practitioner or practitioner group beyond any salary, fee-for-service payments, capitation, or returned withhold.

Capitation Withhold: An incentive arrangement where a certain amount is removed from the negotiated Capitation Payment and might or might not be returned to the Participating Providers within the health care delivery system to cover a specified set of services and administrative costs at a given point in time on the basis of certain criteria and/or factors.

Fee-for-Service Withhold: An incentive arrangement where a certain percentage of the service fee is removed from the base amount of the service fee and might or might not be returned to the Participating Providers within the health care delivery system on the basis of certain criteria and/or factors.

Practitioner Liability: An incentive arrangement where payments are made to or by Participating Providers within the health care delivery system at a given point in time on the basis of certain performance criteria. Practitioner liability does not include those items defined elsewhere on this page.

Referral: Any specialty, inpatient, outpatient, or laboratory services that a practitioner or practitioner group orders or arranges, but does not furnish directly.

Referral Withhold: An arrangement between Contractor and Participating Providers in a health care delivery system to provide an incentive for that system to take on additional financial responsibility in covering probable, future expenses incurred from providing referral health care services to Contractor's OHP Members. These arrangements consist of any amounts Contractor pays Participating Providers for services provided, including the amounts paid for administration. These arrangements may control levels or costs of referral services. These payments should only include arrangements based on referral levels. Arrangements made between Contractor and an intermediate entity who in turn subcontracts with one or more practitioner groups are to be reported.

EXHIBIT J
PREVENTION/DETECTION OF FRAUD AND ABUSE

Contractor shall have in place internal controls, policies or procedures capable of preventing and detecting fraud and abuse activities as they relate to the Oregon Health Plan. This may include operational policies and controls in areas such as complaint and grievance resolution, provider credentialing and contracting, provider and staff education, and corrective action plans to prevent potential fraud and abuse activities. Contractor shall review its fraud and abuse policies annually. If Contractor is also a Medicare contractor, the fraud and abuse policies established by Contractor to meet CMS standards shall be deemed sufficient to meet DHS's requirements for fraud and abuse prevention and monitoring.

1. Services under this Agreement may not be provided by the following persons (or their affiliates as defined in the Federal Requisition Regulations): (a) Persons who are currently suspended, debarred or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issues pursuant to Executive Order No. 12549 or under guidelines implementing such order, (b) Persons who are currently excluded from the Medicaid participation under section 1128 or section 1128A of the Act.

2. Contractor shall not refer OHP Members to such persons and shall not accept billings for services to OHP Members by such persons.

3. Contractor may not knowingly: (1) have a person described in (a) above as a director, officer, partner, or person with beneficial ownership of more than 5% of Contractor's equity, or (2) have an employment, consulting, or other agreement with a person described in 1(a) above for the provision of items and services that are significant and material to Contractor's obligations under this Agreement.

4. Contractor is required to promptly refer all verified cases of fraud and abuse, including fraud by employees and subcontractors of the organization to the Medicaid Fraud Control Unit (MFCU), consistent with the Memorandum of Understanding between DHS and the MFCU. Contractor may also refer cases of suspected fraud and abuse to the MFCU prior to verification.

5. Examples of cases that should be referred:

   (a) Providers who consistently demonstrate a pattern of intentionally reporting encounters or services that did not occur. A pattern would be evident in any case where 20% or more of sampled or audited services are not supported by documentation in the clinical records;

   (b) Providers who consistently demonstrate a pattern of intentionally reporting overstated or up-coded levels of service. A pattern would be evident by 20% or more of sampled or audited services that are billed at a higher level procedure code than is documented in the clinical records;

   (c) Any verified case where the provider purposefully altered, falsified, or destroyed clinical record documentation for the purpose of artificially inflating or obscuring compliance rating or collecting Medicaid payments not otherwise due;

   (d) Providers who intentionally or recklessly make false statements about the credentials of persons rendering care to OHP Members;

   (e) Providers who intentionally fail to render medically appropriate covered services to OHP Members;

   (f) Providers who knowingly charge OHP Members for services that are covered or intentionally balance bill an OMAP Member the difference between the service charge and Contractor's payment, in violation of DHS rules;

   (g) Any case of theft, embezzlement or misappropriation of Title XIX or Title XXI program money.

6. An incident with any of the referral characteristics listed above should be referred to the MFCU. Contractor may also refer cases of suspected fraud and abuse to the MFCU.

7. The MFCU phone number is (503) 229-5725, address 1515 SW 5th Avenue, Suite 410, Portland, Oregon 97201, and fax (503) 229-5120.

8. Incidents of verified or suspected fraud or abuse by an OHP Member should be reported to DHS Fraud Unit:, **P.O. Box 14060, Salem, Oregon 97309-5027, phone number (503) 378-6826, facsimile number (503) 373-1525.**

9. Contractor shall promptly report all fraud and abuse as required under this section **to the MFCU. Contractor shall also notify OMHAS of referrals to MFCU of complaints of fraud and abuse that warrant investigation. This notification shall include the following information:**

   (a) Provider's name and address;
   (b) Source of complaint;
   (c) Nature of complaint;
   (d) The approximate range of dollars involved; and
   (e) The disposition of the complaint when known.

10. Contractor shall cooperate with the MFCU and the DHS Fraud Unit and allow them to inspect, evaluate, or audit books, records, documents, files, accounts, and facilities as required to investigate an incident of fraud or abuse.

11. In the event that Contractor reports suspected fraud, or learns of an MFCU or DHS Fraud Unit investigation, Contractor shall not notify or otherwise advise its subcontractors of the investigation so as not to compromise the investigation.

EXHIBIT K
DEFINITIONS

In addition to any terms that may be defined elsewhere in this Agreement and with the following exceptions and additions, the terms in this Agreement have the same meaning as those terms appearing in Oregon Administrative Rules (OARs) 309-012-0140, 309-032-0535, 309-033-0210, 410-120-0000, and 410-141-0000. The order of preference for interpreting conflicting definitions is this Agreement, Oregon Health Plan Rules of DHS, General Rules of DHS, and Mental Health Rules of DHS.

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

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

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

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

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

Alternative Site: A place where Services are provided other than the service provider's office, clinic or other regular place of business. Alternative Sites are used to assure more accessible and effective delivery of the service and include, but are not limited to, a

school, community center, foster home, Nursing Home, physician's office, home or other natural setting.

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

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

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

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

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

Capacity: The ability to make Covered Services available in a given geographic area relative to the size, location and unique needs of the OHP Membership within it. Indicators of Capacity may be represented as ratios between the number of Participating Providers per 1,000 OHP Members for a given geographic area (county or zip code); as ratios between the number of Participating Providers per 1,000 OHP Members; as ratios between various types of Participating Providers (psychiatrists, case managers) per a set number of OHP Members with specific diagnoses, unique characteristics and/or special needs; as ratios between the number of Participating Providers per the total of OHP Members and other patients; as a function of travel time or distance between the OHP Member's residence and the Participating Provider; as a function of waiting time for regular appointments, urgent care, emergency care and specialty care; as a function of

office waiting time; and as a function of 24-hour care. Measurement of Capacity must consider factors such as geographic or physical barriers (mountains or rivers) which preclude access, service utilization patterns (services being sought outside the immediate vicinity), language or cultural barriers, and needs of migrant or seasonal workers.

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

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

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

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

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

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

Chemical Dependency Provider: A practitioner approved by DHS to provide publicly funded alcohol and drug abuse rehabilitative services.

Child Acuity of Psychiatric Illness (CAPI): An assessment tool used to measure the severity of a child's psychiatric symptoms, functioning and systems support. The tool was developed and published by John Lyons, Ph.D., Northwestern University Medical School.

Child and Adolescent Treatment Program (CATP): The program at Oregon State Hospital for children under age 18.

Children Global Assessment Scale (CGAS): A scale used to measure and condense different aspects of a child's biopsychosocial functioning into a single, clinically meaningful index of severity. The CGAS is an adaptation of the Diagnostic and Statistical Manual Global Assessment Scale for adults by the Department of Psychiatry, Columbia University, published in November 1982. The CGAS is recommended for use with children ages 4 through 16. The CGAS scores are numerically quantified on Axis Five of the DSM multi-axial Diagnosis.

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

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

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

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

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

Community Coordinating Committee: A committee composed of representatives from the local Community Mental Health Program, DHS Children, Adults and Families Services, Juvenile Court, local education district, and Oregon State Hospital, Children and Adolescent Treatment Program (CATP. The committee performs the intake function to assure a child's need for Long Term Psychiatric Care.

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

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

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

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

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

Condition/Treatment Pair: Conditions described in the International Classification of Diseases Clinical Modifications, 9th edition (ICD-9 CM) and treatments described in the current version of the American Medical Association's Physicians' Current Procedural

Terminology (CPT), HCPC, and and BA/ECC Codes established by DHS which, when paired by the HSC, constitute the line items in the Prioritized List of Health Services. Condition/Treatment Pairs may contain many diagnoses and treatments. The pairs are listed in OAR 410-141-0520, Prioritized List of Health Services.

Consultation: Professional advice or explanation given concerning a specific OHP Member to others involved in the treatment process, including Family members, staff members of other human services agencies (such as DHS Senior and People with Disabilities Programs, DHS Children, Adults and Families Services, schools, , OYA,

juvenile justice) and care providers (such as Nursing Homes, foster homes, or residential care facility staff).

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

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

Contractor Representative: The individual within Contractor organization responsible for handling Complaint and Hearing issues. The role of this person is described in Exhibit G, Oregon Health Plan Mental Health Services Client Notices, Grievances, Appeals, and Hearings Process.

Covered Services: Services included in the Capitation Payment paid to Contractor under this Agreement with respect to an OHP Member under this Agreement whenever services are Medically Appropriate for the OHP Member. Services included in the Capitation Payment are described in the State of Oregon, Oregon Health Plan Service Categories for Per Capita Costs, October 2002 through September 2003. The Capitation Payment is based on the number of condition/treatment pair lines of the List of Prioritized Health Services funded by the Legislature and adopted in OAR 410-141-0520. The Covered Services described in this agreement shall be substituted with and/or expanded to include Flexible Services and Flexible Service Approaches identified and agreed to by Contractor, the OHP Member and, as appropriate, the family of the OHP Member as being an efficacious alternative. Covered Services are limited in accordance with OAR 410-141-0500, Excluded Services and Limitations for Oregon Health Plan Clients.

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

Culturally Competent: The Capacity to provide services in an effective manner that is sensitive to the culture, race, ethnicity, language and other differences of an individual. Such services may include, but are not limited to, use of bilingual and bicultural staff,

provision of services in culturally appropriate alternative settings, and use of bicultural Paraprofessionals as intermediaries with professional staff.

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

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

Department of Human Services (DHS): The Department is comprised of seven clusters and the Office of the Director. The OMHAS is a program office within the Health Services cluster.

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

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

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

Disenrollment: The act of discharging an OHP Member from a Contractor's responsibility. After the effective date of Disenrollment an OHP Client is no longer

required to obtain Covered Services from the Contractor, nor be referred by the Contractor.

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

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

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

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

Emergency Service: Covered Services that are needed immediately or appear to be needed immediately because of an injury, sudden illness, or exacerbation of an illness that would have meant risk of permanent damage to the OHP Member's health. See definition for Twenty-four (24) Hour Urgent and Emergency Services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Fully Capitated Health Plans (FCHPs): Prepaid Health Plans that contract with DHS to provide physical health care services under the OHP Medicaid Demonstration Project and State Children's Health Insurance Program.

Geropsychiatric Treatment Service: Four units at Oregon State Hospital serving frail elderly persons with mental disorders, head trauma, advanced dementia, and/or concurrent medical conditions who cannot be served in community programs.

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

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

Health Care Professional: Persons with current and appropriate licensure, certification, or accreditation in a medical, mental health or dental profession, which include but are not limited to: medical doctors (including psychiatrists), osteopathic physicians, psychologists, registered nurses, nurse practitioners, licensed practical nurses, certified medical assistants, physician assistants, QMHAs, QMHPs, dentists, dental hygienists, denturists, and certified dental assistants.

Health Services Commission (HSC): The governing body responsible for the OHP Medicaid Demonstration Project and State Children's Health Insurance Program Prioritized List of Health Services. The HSC determines the Condition/Treatment Pairs to be included on the Prioritized List of Health Services and determines the ranking of each pair.

Hearing Officer: An individual designated by DHS to conduct a hearing on DHS's behalf. The role of the Hearing Officer is is described in Exhibit G, Oregon Health Plan Mental Health Services Client Notices, Complaint and Hearings Process.

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

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

Insolvency: Unable to meet debts or discharge liabilities.

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

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

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

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

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

JCAHO: The Joint Commission on Accreditation of Healthcare Organizations.

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

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

Local Mental Health Authority (LMHA): As defined in ORS 430.620, the county court or board of commissioners of one or more counties who choose to operate a CMHP; or, if the county declines to operate or contract for all or part of a CMHP, the board of directors

of a public or private corporation which contracts with DHS to operate a CMHP for that county.

Local and/or Regional Allied Agencies: These include, but are not limited to, LMHA, CMHPs, DHS Children, Adults and Families Services, Area Agencies on Aging, Commission on Children and Families, Department of Corrections, DHS Seniors and People with Disabilities Program , OYA, DHS Rehabilitation Services under the Community Services Program, housing authorities, local schools, special education, law enforcement agencies, adult criminal justice and juvenile justice, developmental disability services, Chemical Dependency Providers, residential providers, Oregon State Hospital, and Prepaid Health Plans.

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

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

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

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

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

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

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

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

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

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

Mental Health Organization (MHO): A Prepaid Health Plan under contract with DHS to provide Covered Services under the OHP Medicaid Demonstration Project and State Children's Health Insurance Program. MHOs can be FCHPs, CMHPs or private MHOs or combinations thereof.

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

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

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

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

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

Office of Medical Assistance Programs: The DHS program responsible for coordinating the Medical Assistance Program for the State of Oregon.

Office of Mental Health and Addiction Services (OMHAS): The program office of DHS responsible for the administration of mental health services and policy and programs for chemical dependency prevention, intervention, and treatment services for the State of Oregon.

OHP Member: As used in this Agreement, an individual found eligible by a program of DHS to receive health care services under the OHP Medicaid Demonstration Project or State Children's Health Insurance Program and who is enrolled with Contractor under this Agreement.

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

OMHAS Representative: The individual within the Office of Mental Health Services designated to handle DHS Administrative Hearings requested by OHP Members. The role of OMHAS Representative is described in Exhibit G, Oregon Health Plan Mental Health Services Client Notices, Grievances, Appeals, and Hearings Process.

Oregon Health Plan (OHP): Oregon's health care reform effort consisting of a Medicaid Demonstration Project, State Children's Health Insurance Program, an individual insurance program for persons excluded from health insurance coverage due to pre-existing health conditions, and a group insurance program for small businesses. One

objective of this reform effort includes universal coverage for Oregonians. In the context of this Agreement, Oregon Health Plan refers to the OHP Medicaid Demonstration Project and State Children's Health Insurance Program.

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

Oregon Health Plan (OHP) Medicaid Demonstration Project: The project which expands Medicaid eligibility to Oregon residents with three components, OHP Plus, OHP Standard, and Family Health Insurance Assistance Program. The OHP Medicaid Demonstration Project relies substantially upon prioritization of health services and managed care to achieve the public policy objectives of access, cost containment, efficacy, and cost effectiveness in the allocation of health resources.

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

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

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

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

Other Inpatient Services: Services which are equivalent to Acute Inpatient Hospital Psychiatric Care but which are provided in a nonhospital setting.

Outpatient Hospital Services: Covered services received in an outpatient hospital setting where the OHP member has not been admitted to the facility as an inpatient, as defined in the DHS Hospital Services Guide.

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

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

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

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

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

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

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

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

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

Prepaid Health Plan (PHP): A managed care organization that contracts with DHS on a case managed, prepaid, capitated basis under the OHP Medicaid Demonstration Project and State Children's Health Insurance Program. PHPs may be Dental Care Organizations (DCO), FCHP, Chemical Dependency Organizations (CDO), or MHO.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Quality Assurance (QA): A process to promote and confirm consistency of performance and to reduce variance in performance. A Quality Assurance process serves to demonstrate or document the degree of attainment of predetermined goals and Benchmarks.

Quality Assurance/Quality Improvement (QA/QI) Plan: A plan which describes the MHO's QA and QI process.

Quality Improvement (QI): A process to simultaneously promote consistency of performance and to promote meaningful change in Measurable Objectives. The process seeks to improve performance and to adjust Measurable Objectives and Benchmarks.

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

Reasonable Accommodation: Consistent with the ADA and Section 504 of the Rehabilitation Act of 1973, a modification to policies, practices, or procedures when the modification is necessary to avoid discrimination on the basis of Disability unless the service provider can demonstrate that making the modification would fundamentally alter the nature of the service, program or activity. Reasonable Accommodations may include, but are not limited to, activities such as the following: (1) reading, or providing a tape of, material otherwise provided in written format to a person with a visual impairment; (2) providing a service in a more accessible location for a person with a mobility and other impairment; (3) providing assistance to a person with a Disability in completing applications and other paperwork necessary to receipt of services; and (4) modifying a waiting area layout to accommodate a person in a wheelchair.

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

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

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

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

Request for Proposals (RFP): The process used by DHS to solicit offers to deliver managed mental health services under the OHP Medicaid Demonstration Project.

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

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

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

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

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

Service: The care, treatment, service coordination or other assistance provided to an OHP Member.

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

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

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

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

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

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

Stakeholders: Persons, organizations and groups with an interest in how Covered Services are delivered under the MHO Agreement. Stakeholders may include, but are not

limited to, OHP Members, Consumers, Families, Local and/or Regional Allied Agencies, child psychiatrists, child advocates, advocacy groups, and other groups.

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

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

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

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

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

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

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

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

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

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

Third Party Resources: Those payments, benefits or resources available from certain categories of resources, including but not limited to the following: under a federal or state workers' compensation law or plan; for items or services furnished by reason of membership in a prepayment plan; for items or services provided or paid for directly or indirectly by a health insurance plan; for items or services provided or paid for directly or indirectly as health benefits from a governmental entity, such as Veteran's Administration, Armed Forces Retirees and Dependent Act (CHAMPVA), Armed Forces Active Duty and Dependents Military Medical Benefits Act (CHAMPUS), and Medicare Parts A and B; to OHP Members who are eligible for services under another state's Title XIX, Title XXI, or state-funded Medical Assistance Program; through other community resources; or for tort or estate recoveries.

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

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

Hospital Psychiatric Care; and Covered Services provided in a variety of residential settings.

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

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

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

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

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

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

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

Usual and Customary Charges: A required field in the encounter Minimum Data set which reflects the provider's charge per unit of service established in accordance with

OAR 410-120-0000 or other applicable state and federal laws, rules and regulations, not in excess of the provider's usual and customary charge to the general public.

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

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

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

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

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