

May 5, 2016

Board of Commissioners
Clackamas County

Members of the Board:

**Approval of a Revenue Agreement with CareOregon Inc. for Primary Care, Dental, and
Chemical Dependency Treatment Services**

Purpose/Outcomes	The purpose of this agreement is to provide Primary Care, Dental and Chemical Dependency Treatment Services to CareOregon Members.
Dollar Amount and Fiscal Impact	The total amount of the agreement is unknown, because the number of clients who will be enrolled with CareOregon, Inc. cannot be projected with certainty. No County General funds are involved.
Funding Source	Health Center Clinics
Duration	Upon Signature – Until Terminated
Previous Board Action	No Previous Board Action
Strategic Plan Alignment	1. Improved community safety and health 2. Ensure safe, healthy and secure communities
Contact Person	Deborah Cockrell 503-742-5495
Contract No.	7642

Background

The Clackamas County Health Centers Division (CCHCD) of the Health, Housing & Human Services Department requests the approval of a revenue agreement with CareOregon, Inc. for the purpose of providing Primary Care, Dental, and Chemical Dependency Treatment Services.

This agreement will allow CareOregon, Inc. to refer their clients to CCHCD for treatment services.

This is a revenue contract for CCHCD. The total amount of the agreement is unknown because the number of authorized referrals cannot be projected with certainty. No County General Funds are involved. The agreement is effective upon execution by both parties and will continue until terminated. This document was reviewed by County Counsel on April 7, 2016.

Recommendation

Staff recommends the Board approval of this contract and authorizes Richard Swift, H3S Director to sign on behalf of Clackamas County.

Respectfully submitted,

Richard Swift, Director
Health, Housing & Human Services

Contract # 7642

CAREOREGON PROVIDER AGREEMENT

Contracted Provider: Clackamas County Community Health Division

Effective Date of Agreement: _____

Contract # 7642

PROVIDER AGREEMENT

THIS PROVIDER AGREEMENT (“**Agreement**”) is made and entered into as of _____ (“**Effective Date**”) by and between CareOregon, Inc. (“**CareOregon**”) and Clackamas County Community Health Division (“**Contracted Provider**”). CareOregon and Contracted Provider are sometimes referred to together as the “**Parties**” and individually as a “**Party**.”

WHEREAS, CareOregon arranges for the provision of healthcare services to individuals eligible for certain items and services under certain Benefit Plans and CareOregon seeks to include health care providers in one or more provider networks for such Benefit Plans; and

WHEREAS, Contracted Provider provides health care items and services to the general public by health care providers employed by or subcontracted with Contracted Provider; and

WHEREAS, CareOregon and Contracted Provider desire to enter into this Agreement whereby Contracted Provider will provide health care items and services to enrollees of Benefit Plans and receive payment therefore, all subject to and in accordance with the terms and conditions of this Agreement.

NOW THEREFORE, the Parties agree as follows:

ARTICLE I. CONSTRUCTION

Section 1.01 Benefit Plans. This Agreement is designed for use with a variety of providers and Benefit Plans. Provisions specific to particular providers and Benefit Plans are included in Exhibits to the Agreement.

Section 1.02 Rules of Construction. The following rules of construction apply to this Agreement: (a) the word “include,” “including” or a variant thereof shall be deemed to be without limitation; (b) the word “or” is not exclusive; (c) the word “day” means calendar day unless otherwise specified; (d) the term “business day” means Monday through Friday, except Federal holidays; (e) all words used in this Agreement will be construed to be of such gender or number as the circumstances require; (f) references to specific statutes, regulations, rules or forms include subsequent amendments or successors to them; and (g) references to a government department or agency include any successor departments or agencies to it.

ARTICLE II. DEFINITIONS

In addition to terms defined elsewhere in this Agreement, the following capitalized terms when used in this Agreement shall have the meanings set forth below; provided, however, that if an identical term is defined in an Exhibit, the definition in the Exhibit shall control with respect to Benefit Plans governed by the Exhibit.

Section 2.01 “Affiliate” means, with respect to a particular entity, another entity that directly, or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with, the entity. An entity “controls” an entity in which it has the power to vote, directly or indirectly, 50 percent or more of the voting interests in such entity or in the case of a partnership if it is a general partner, or the power to direct or cause direction of management and policies of such entity, whether through the ownership of voting shares, by contract or otherwise.

Section 2.02 “Benefit Plan” means a health benefit policy or other health benefit contract or coverage document: (a) issued by CareOregon, its successors or assigns; (b) issued by The HealthPlan of CareOregon, Inc. its successors or assigns; (c) administered by CareOregon pursuant to a Government Contract (for example a benefit plan offered by a Coordinated Care Organization (“CCO”)) with which CareOregon contracts to provide administrative or other services, or (d) issued by a private insurance carrier. Benefit Plans are set forth in Exhibit A hereto. Exhibit A may be amended or replaced pursuant to paragraph 8.14 hereof. Benefit Plans and their designs are subject to change periodically.

Section 2.03 “Carve Out Agreement” means an agreement between CareOregon and a third party Participating Provider whereby the third party assumes financial responsibility for or may provide certain management services related to particular Covered Services. Examples of possible Carve Out Agreements include agreements for behavioral health, radiology, laboratory, dental, vision, or hearing services.

Section 2.04 “Clean Claim” means a claim for Covered Services provided to a Member that (a) is received timely by CareOregon; (b) has no defect, impropriety, or lack of substantiating documentation from the Member’s medical record regarding the Covered Services; (c) is not subject to coordination of benefits or subrogation; (d) is on a completed, legible CMS 1500 form or UB-04 form or electronic equivalent that follows then current HIPAA Administrative Simplification ASC X12 837 standards and additional specific requirements in the Program Policies, including all then-current guidelines regarding coding and inclusive code sets; and (e) includes all relevant information necessary for CareOregon or Payor to (1) meet requirements of Laws and Program Requirements for reporting of Covered Services provided to Members, and (2) determine Payor liability, and ensure timely processing and payment. A Clean Claim does not include a claim from a Contracted Provider who is under investigation for fraud or abuse, or a claim under review for Medical Necessity.

Section 2.05 “Coordinated Care Organization” means an entity that has entered into a Health Plan Services Contract with the State of Oregon, acting by and through its Oregon Health Authority (“OHA”), Division of Medical Assistance Programs (“DMAP”), to provide and pay for Coordinated Care Services.

Section 2.06 “Covered Services” means Medically Necessary health care items and services covered under a Benefit Plan.

Section 2.07 “Credentialing Criteria” means CareOregon’s or a Program’s criteria for the credentialing or re-credentialing of Providers.

Section 2.08 “**DHHS**” means the U.S. Department of Health and Human Services, including its agency the Centers for Medicare and Medicaid Services (“**CMS**”) and its Office of Inspector General (“**OIG**”).

Section 2.09 “**Emergency Services**” shall be as defined in the applicable Program Attachment or Benefit Plan.

Section 2.10 “**Encounter Data**” means encounter information, data, and reports for Covered Services provided to a Member that meets the requirements for Clean Claims.

Section 2.11 “**Federal Health Care Program**” means a Federal health care program as defined in Section 1128B(f) of the Social Security Act, and includes Medicare, Medicaid and (State Children’s Health Insurance Program or “**CHIP**”).

Section 2.12 “**Government Contract**” means a contract to provide health benefits coverage the parties to which are a Governmental Authority and: (i) CareOregon or (ii) a government-authorized entity (such as a CCO) with which CareOregon has contracted to provide administrative services.

Section 2.13 “**Governmental Authority**” means the United States of America, a State, or any department or agency thereof having jurisdiction over CareOregon, Contracted Provider or its Providers, or their respective Affiliates, employees, subcontractors or agents.

Section 2.14 “**Ineligible Person**” means an individual or entity who (a) is currently excluded, debarred, suspended or otherwise ineligible to participate in: (i) any Federal Health Care Program, as may be identified in the List of Excluded Individuals/Entities maintained by the OIG; or (ii) Federal procurement or nonprocurement programs, as may be identified in the Excluded Parties List System maintained by the General Services Administration, (b) has been convicted of a criminal offense subject to OIG’s mandatory exclusion authority for Federal Health Care Programs described in Section 1128(a) of the Social Security Act, but has not yet been excluded, debarred or otherwise declared ineligible to participate in such programs, or (c) is currently excluded, debarred, suspended or otherwise ineligible to participate in State medical assistance programs, including Medicaid or CHIP, or State procurement or nonprocurement programs as determined by a State Governmental Authority.

Section 2.15 “**Laws**” means any and all applicable laws, rules, regulations, statutes, orders, standards, guidance and instructions of any Governmental Authority, as adopted, amended, or issued from time to time, including (a) the Social Security Act, including Titles XVIII (“**Medicare**”), XIX (“**Medicaid**”) and XXI (CHIP), (b) the Health Insurance Portability and Accountability Act of 1996 (“**HIPAA**”), (c) federal and state privacy laws other than HIPAA, (d) federal and state laws regarding patients’ advance directives, (e) state laws and regulations governing the business of insurance, (f) state laws and regulations governing third party administrators or utilization review agents, and (g) state laws and regulations governing the provision of health care services.

Section 2.16 “**Medically Necessary**” or “**Medical Necessity**” shall be as defined in the applicable Program Attachment or Benefit Plan.

Section 2.17 “Member” means an individual properly enrolled in a Benefit Plan and eligible to receive Covered Services at the time such services are rendered.

Section 2.18 “Member Expenses” means copayments, coinsurance, deductibles or other cost share amounts, if any, that a Member is required to pay for Covered Services under a Benefit Plan.

Section 2.19 “Never Events” means serious, largely preventable, harmful clinical events, including without limitation, those events defined as “never events” by CMS and Serious Reportable Events (“SREs”) as identified by the National Quality Forum in its most recent list of SREs, as such terms may be re-defined from time to time.

Section 2.20 “Non-Contracted Services” means Covered Services that are (a) subject to Carve Out Agreements and not approved by CareOregon in advance as further described in this Agreement, or (b) provided by an Ineligible Person.

Section 2.21 “Payor” means CareOregon, Inc. except with respect to the “**CCO Payor Arrangements**” identified in Exhibit A hereto for which the CCO shall be the Payor, or the “**Private Insurance**” arrangements identified in Exhibit A hereto for which the Private Insurance shall be the Payor.

Section 2.22 “Participating Provider” means an individual or entity that has entered into a contract with CareOregon, or is a subcontractor to an entity that has entered into a contract with CareOregon, to provide or arrange for the provision of Covered Services to Members and who has been approved by CareOregon to provide such services.

Section 2.23 “Program” means (a) a Federal Health Care Program, or (b) a commercial insurance program, including without limitation a program created under Laws regarding health insurance exchanges.

Section 2.24 “Program Attachment” means the terms and conditions of a Provider’s participation in Benefit Plans under a Program, as set forth in Exhibit B.

Section 2.25 “Program Requirements” means the requirements of Governmental Authorities or insurance carrier governing a Benefit Plan, including where applicable the requirements of a Government Contract.

Section 2.26 “Program Policies” means, collectively, the CareOregon Provider manual, quick reference guides, and educational materials setting forth CareOregon’s or a Program’s requirements, rules, policies and procedures applicable to Participating Providers, as adopted or amended by CareOregon or a Program from time to time, including requirements, rules, policies and procedures regarding fraud, waste and abuse; accreditation, credentialing/re-credentialing of providers, Member eligibility verification, prior authorization, submission of claims and Encounter Data, claims payment, overpayment recoupment, utilization review/management, disease and case management, quality assurance/improvement, model of care, advance directives, collection of Member Expenses, Member rights, including reimbursement of Member Expenses collected in excess of the maximum out of pocket amount under a Benefit Plan; and Member or Provider grievances and appeals.

Section 2.27 “Provider” means (a) Contracted Provider or (b) other individual or entity that is subject to an employment arrangement or direct or indirect subcontract with Contracted Provider to provide or arrange for the provision of Covered Services to Members under this Agreement and who has been approved by CareOregon to provide such services.

ARTICLE III. SCOPE

Section 3.01 Non-Contracted Services. Non-Contracted Services are outside the scope of this Agreement.

Section 3.02 Providers May Communicate with Members. Providers may freely communicate with Members about their treatment regardless of Benefit Plan coverage limitations. CareOregon does not dictate or control clinical decisions respecting a Member’s medical treatment or care. Medical care is the responsibility of the treating Provider regardless of any coverage determination by CareOregon. Nothing in this Agreement shall be interpreted to permit interference by CareOregon with communications between a Contracted Provider or its Providers and a Member regarding the Member’s medical condition or available treatment options.

Section 3.03 Agreement Not Exclusive. This is not an exclusive agreement for either Party, and there is no guarantee that: (a) CareOregon will participate in any particular Program; or (b) any particular Benefit Plan will remain in effect.

Section 3.04 Provider Networks. Subject to Laws and Program Requirements, CareOregon reserves the right to create distinct provider networks for a Benefit Plan, and to determine Provider participation in such networks.

Section 3.05 No Obligation to Assign Members. Subject to Laws and Program Requirements, CareOregon reserves the right to approve any Provider’s participation under this Agreement, or to terminate or suspend any Provider from participation under this Agreement or in one or more particular Benefit Plans. CareOregon is not obligated to refer or assign a minimum number of Members to or maintain a minimum number of Members with a Provider.

ARTICLE IV. CONTRACTED PROVIDER OBLIGATIONS

Section 4.01 Providers. Contracted Provider warrants and represents that it has provided CareOregon with the necessary information for itself and its Providers as of the Effective Date in a form and format acceptable to CareOregon. Such information is required to maintain Contracted Provider files for directory use, assignment and claims payment. Contracted Provider shall provide notice to CareOregon of any change in the information within 30 days of the change.

(a) Employed Providers. Contracted Provider shall maintain and enforce binding internal policies and procedures or agreements with its employed Providers that are consistent with and require adherence to this Agreement. Contracted Provider shall provide CareOregon

with such information requested by CareOregon, or as required by a Governmental Authority or accreditation body, necessary to verify the employment of its employed Providers.

(b) Subcontracted Providers. The following applies if Contracted Provider contracts with independent contractor providers to perform the services hereunder (Subcontracted Provider), for example where Contracted Provider is an independent practice association, physician hospital organization or physician group:

(i) Contracted Provider shall maintain and enforce written agreements with its Subcontracted Providers that are consistent with and require Subcontracted Provider's adherence to this Agreement. Contracted Provider shall impose this contractual obligation upon its Subcontracted Providers (e.g. that the Subcontracted Provider require adherence with this Agreement by any providers Subcontracted Provider contracts with to perform services hereunder). Upon CareOregon's request, Contracted Provider shall provide CareOregon with copies of agreement templates used with their Subcontracted Providers, and (1) copies of the first page, signature page and other pages necessary to identify the contracting parties and effective date for each such agreement, or (2) copies of entire agreements with Subcontracted Providers. Compensation provisions in copies of such agreements may be redacted, except where compensation information is required by Governmental Authorities. In no event shall a Subcontracted Provider agreement supersede this Agreement respecting matters covered by this Agreement. Notwithstanding anything to the contrary in any such agreement, this Agreement shall control over the terms of any such agreement in all respects as to matters covered by this Agreement.

(ii) Contracted Provider shall require its Subcontracted Providers to maintain and enforce binding internal policies and procedures or agreements with their employed Providers that are consistent with and require adherence to this Agreement. Subcontracted Providers shall provide CareOregon with such information requested by CareOregon, or as required by a Governmental Authority or accreditation body, necessary to verify the employment of their employed Providers.

(iii) Contracted Provider shall include in its agreements with Subcontracted Providers performing services hereunder a provision stating that any obligation of Contracted Provider in this Agreement shall apply to Subcontracted Providers to the same extent that it applies to Contracted Provider. Contracted Provider shall require the timely and faithful performance of this Agreement by Subcontracted Providers.

(c) Credentialing. All Providers must meet the Credentialing Criteria. Subject to Laws and Program Requirements, (a) CareOregon conducts credentialing of providers before they begin providing Covered Services and re-credentialing from time to time thereafter as required for CareOregon's compliance with Laws, Program Requirements and accreditation standards, and Providers shall consent to and cooperate with such credentialing/re-credentialing, which may include site reviews, and (b) until successful completion of credentialing of a provider by CareOregon, (i) the provider shall not be added as a Participating Provider under this Agreement, and (ii) the provision of, and payment for, authorized Covered Services to Members by the provider shall be subject to CareOregon's or Payor's policies and procedures for non-participating providers.

Section 4.02 Covered Services. Contracted Provider shall provide Covered Services to Members, subject to and in accordance with the terms and conditions of this Agreement.

(a) **Standards.** Contracted Provider shall ensure that Providers shall provide Covered Services in accordance with Laws and generally accepted standards of medical practice, including recognized clinical protocols and guidelines where available. Contracted Provider shall ensure that Covered Services are available to Members on a 24 hour/day, 7 day/week basis, except Providers who do not provide Emergency Services shall ensure that Covered Services are available to Members in accordance with standard operating hours for each Provider location and shall maintain an after-hours phone service for individuals to seek instructions in the event of an emergency.

(b) **Eligibility.** Except for Emergency Services, Contracted Provider shall verify Member eligibility in accordance with the Program Policies before providing Covered Services to a Member. CareOregon provides member eligibility information through CareOregon's provider website and other means. For Emergency Services, Providers shall verify Member eligibility within 24 hours of the Member being stabilized or the Provider learning the individual may be a Member, whichever is later. Members' eligibility status is subject to retroactive disenrollment, and CareOregon may, except where prohibited by Laws or Program Requirements, recoup payments to Contracted Provider for items or services provided to such individuals after the effective date of disenrollment even if such items and services were authorized by CareOregon.

(c) **Prior Authorization.** Except for Emergency Services or where prior authorization is not required by the Program Policies, Providers shall obtain prior authorization for Covered Services in accordance with the Program Policies. Except where prohibited by Laws or Program Requirements, CareOregon may deny payment for Covered Services where a Provider fails to meet requirements for prior authorization.

(d) **Referrals.** Providers shall not refer Members to other health care providers, including other Participating Providers, for Covered Services without the approval of CareOregon, except (a) in case of Emergency Services, (b) when Member self-referral is permitted by the Benefit Plan, or (c) as permitted in Program Policies provisions regarding utilization management. When making a referral to another health care provider, a Provider shall furnish the other provider complete information on treatment procedures and diagnostic tests performed prior to such referral, which may include providing copies of the medical records.

(e) **Non-Covered Services.** Every time a Provider provides items or services to a Member that are not Covered Services, before providing the items or services the Provider shall (a) inform the Member of the specific items or services that are not Covered Services and that they will not be paid for by CareOregon or Payor, and (b) obtain the Member's written agreement to pay for such specific items or services after being so advised. Provider shall contact CareOregon for a coverage determination in any case where Provider is unsure if an item or service is a Covered Service.

(f) **Carve-Out Agreements.** If at any time during the Term CareOregon or Payor has a Carve-Out Agreement in place with a third party Participating Provider to provide Covered

Services to Members subject to a Carve-Out Agreement (“**Carve-Out Vendors**”), for as long as such Carve-Out Agreement is in effect, services subject to the Carve-Out Agreement shall not be Covered Services under this Agreement, except for (a) Emergency Services or (b) Covered Services authorized by CareOregon in advance in accordance with the Program Policies, in which cases the terms and conditions of this Agreement, including compensation, shall apply. CareOregon shall notify Contracted Provider of Carve-Out Agreements through the Program Policies or other notice. Subject to the agreement of the Carve-Out Vendor, Providers may enter into separate agreements with the Carve-Out Vendor, and, except as set forth in this paragraph, the compensation in this Agreement shall not apply to services of Contracted Provider pursuant to the Contracted Provider’s agreement with the Carve-Out Vendor. Unless otherwise approved by CareOregon in its written notice to Contracted Provider, if Contracted Provider does not enter into a separate agreement with a Carve-Out Vendor, Contracted Provider will be treated as non-participating with CareOregon and Carve-Out Vendor for services subject to the Carve-Out Agreement. If a Carve-Out Agreement expires or is terminated during the Term, Contracted Provider shall thereafter provide the Covered Services that were subject to the Carve-Out Agreement to Members, subject to and in accordance with the terms and conditions of this Agreement, including compensation.

Section 4.03 Claims and Encounter Data/EDI

(a) Clean Claims. Contracted Provider shall prepare and submit Clean Claims to CareOregon within 120 days, or such shorter time period required by Laws or Program Requirements, of the date of a Covered Service or the date of discharge from an inpatient facility, as the case may be. Unless prohibited by Laws or Program Requirements, CareOregon or Payor may deny payment for any claims that fail to meet CareOregon’s or Payor’s submission requirements for Clean Claims or that are received after the time limit in this Agreement for filing Clean Claims. Contracted Provider shall use its best commercial efforts to communicate with CareOregon and Payor, submit claims, determine Member eligibility, receive payments and refund payments, receive explanation of benefits, check claims status, submit requests for claims adjustment, and perform other Benefit Plan administrative functions, through such electronic media, including web-based or other online resources or functionalities, as are made available to Contracted Provider by CareOregon or Payor from time-to-time.

(b) Additional Reports. If CareOregon requests additional information, data or reports from a Provider regarding Covered Services to Members for any reason, including for purposes of risk adjustment data validation, even if CareOregon has already paid claims or accepted Encounter Data related to the Covered Services, the Provider shall provide the information, data or reports as requested by CareOregon.

(c) NPI Numbers/Taxonomy Codes. Contracted Provider shall give CareOregon its Providers’ National Provider Identification (“**NPI**”) numbers and Provider taxonomy codes prior to its Providers becoming Participating Providers under this Agreement. Payment of compensation for Covered Services is conditioned on Providers including their NPI numbers and Provider taxonomy codes on claims or Encounter Data submitted under this Agreement, and CareOregon or Payor may deny payment for Covered Services where Contracted Provider fails to meet these requirements.

(d) Electronic Transaction Requirements. Contracted Provider shall use commercially reasonable efforts to transition to submission of claims and Encounter Data to CareOregon and Payor electronically. For electronically submitted claims, Contracted Provider shall follow the requirements for electronic data interchange in the then-current (1) HIPAA Administrative Simplification transaction standards and (2) the Program Policies.

(e) EFT/Remittance Advice. If Contracted Provider is able to accept payments and remittance advice electronically: (a) Contracted Provider shall register and complete the forms for electronic funds transfer and electronic remittance advice as soon as practicable, but no later than 60 days following CareOregon's confirmation of Contracted Provider's status as a Participating Provider, and (b) if possible Contracted Provider shall accept payments and remittance advice electronically, if CareOregon or Payor prefers to submit electronically. If Contracted Provider is not able to accept payments and remittance advice electronically, Contracted Provider shall make good faith efforts to be able to accept electronic funds transfer and electronic remittance within 12 months after the Effective Date.

(f) Coordination of Benefits. CareOregon and Payor shall coordinate payment for Covered Services in accordance with the terms of a Member's Benefit Plan and Laws. Contracted Provider shall provide CareOregon or Payor with electronic versions of explanations of benefits and other documents and information in their possession regarding insurance covering a Member that is primary to the Member's Benefit Plan. Providers shall bill primary insurers for items and services they provide to a Member before they submit claims for the same items or services to CareOregon or Payor. If Payor is not the primary payor for Covered Services provided to a Member, then when not prohibited by Laws or Program Requirements, Payor's payment to Provider for such services shall not exceed the compensation in this Agreement less amounts payable by the primary payor or payors, less Member Expenses. Unless prohibited by Laws and Program Requirements, Payor (or CareOregon on Payor's behalf) may recoup payments for items or services provided to a Member where other payors are determined to be responsible for payment for such items and services and, Payor shall provide such information in connection with such action as is required by applicable law, if any.

(g) Subrogation. Contracted Provider shall follow CareOregon and Payor policies and procedures regarding subrogation activity. In any instance where, as a consequence of liability imposed by law, a third party is found responsible for satisfaction of a claim for which Payor has paid Contracted Provider, and where Payor is unable to recover directly from the third party because the third party has already paid Contracted Provider for the claim, Payor may (or CareOregon May on Payor's behalf) recover from Contracted Provider the amounts it paid Contracted Provider for such claims.

(h) No Inducement to Withhold Covered Services. No payment made by Payor under this Agreement is intended as a financial incentive or inducement to reduce, limit or withhold Covered Services from Members.

Section 4.04 Member Protections

(a) No Discrimination. Contracted Provider shall not, and shall ensure its Providers shall not, discriminate in their treatment of Members based on Members' health status, source of

payment, cost of treatment, participation in Benefit Plans, race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, or genetic information or any other status prohibited by Laws.

(b) Member Protections Against Collections. In no event including nonpayment by Payor, Payor's insolvency or breach of this Agreement, shall Contracted Provider or any of its Providers bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Member or persons acting on any Member's behalf, for amounts that are the legal obligation of Payor. This provision (a) shall survive termination or expiration of this Agreement regardless of the cause giving rise to termination or expiration, (b) shall be construed for the benefit of Members, (c) does not prohibit collection of Member Expenses where lawfully permitted or required, and (d) supersedes any oral or written agreement to the contrary now existing or hereafter entered into between Covered Provider (or any Provider) and Members or persons acting on behalf of a Member.

(c) Member Obligation Limited to Member Expenses. Regardless of any denial of a claim or reduction in payment to Contracted Provider by Payor, in no event will a Member be responsible for payment for any Covered Services other than Member Expenses. However, Members shall not be responsible for Member Expenses where collection of Member Expenses is prohibited by Laws, Program Requirements or this Agreement. If payment of an amount sought in a claim is denied or reduced by Payor, Contracted Provider shall adjust Member Expenses accordingly.

(d) Collection of Member Expenses. Except where collection of Member Expenses is prohibited by Laws, Program Requirements or this Agreement, Contracted Provider shall (a) collect Member Expenses directly from the Member, and (b) not waive, discount or rebate any such amounts except as permitted by and in accordance with Laws and Program Requirements, including without limitation laws regarding prohibited inducements to Federal Health Care Program beneficiaries.

(e) No Billing Where Prohibited. Contracted Provider shall not bill Members for any items or services, such as missed appointments or administrative fees, where such billing is prohibited by Laws or Program Requirements.

(f) Facilitation of Payment by Payor. Where CareOregon is not the Payor, CareOregon shall cooperate in facilitating payment to Contracted Provider by Payor hereunder, however, Contracted Provider shall look solely to the Payor for payment for services provided hereunder. CareOregon will enter into arrangements with Payors requiring them to comply with the Contracted Provider payment provisions hereunder.

Section 4.05 Provider Program Policies. The Program Policies supplement and are made a part of and are incorporated into this Agreement. Contracted Providers shall, and shall require their Providers to, comply with the Program Policies. CareOregon may amend the Program Policies from time to time upon notice to Contracted Provider by posting to CareOregon's provider website, email or other means of notice permitted by this Agreement, provided that in the case of material revisions to the Program Policies, CareOregon shall provide notice in accordance with the provisions of this Agreement regarding written notice in paragraph 8.12 and

8.14 hereof, in which event changes to the Program Policies shall become effective 30 days after such posting or notice, or as of such other time period required for CareOregon to comply with Laws, Program Requirements or accreditation standards. Contracted Provider shall have and maintain systems necessary for access to CareOregon's provider website, and check for revisions to the Program Policies from time to time, which Program Policies may be posted on CareOregon's provider website or may be accessible through a link posted on CareOregon's provider website.

Section 4.06 Quality Improvement. Providers shall comply with CareOregon's quality improvement programs, including those designed to improve quality measure outcomes in the then-current Healthcare Effectiveness Data and Information Set ("HEDIS") or other quality measures. CareOregon may audit Contracted Provider periodically and upon request Contracted Provider shall provide Records to CareOregon for HEDIS or other quality reasons and risk management purposes. CareOregon desires open communication with Contracted Provider regarding CareOregon's quality improvement initiatives and activities.

Section 4.07 Alternative Payment Methods. While there is no guarantee under this Agreement, Payor may offer certain Providers the opportunity to participate in Alternative Payment Methods incentive programs ("Alternative Payment Methods"). If offered, an Alternative Payment Method will be designed to promote preventive care, quality care and/or ensure the appropriate and cost effective use of Covered Services through appropriate utilization. Alternative Payment Methods may be based in whole or part on achieving certain quality benchmarks using HEDIS or some similar measure, achieving certain Member satisfaction, using electronic funds transfers and remittance or other criteria. If offered, Payor will set forth the specific terms and conditions of the Alternative Payment Method in a separate policy and Contracted Provider's participation shall be subject to the terms and conditions of this Agreement and any applicable policies. CareOregon and Contracted Provider agree that no Alternative Payment Method shall limit Medically Necessary services.

Section 4.08 Utilization Management. Providers shall cooperate and participate in CareOregon's utilization review and case management programs. CareOregon's utilization review/case management programs may include provisions for (a) verification of eligibility and prior authorization for Covered Services, (b) concurrent and retrospective reviews, (c) requirements regarding referrals to third party Participating Providers, including those that are party to Carve-Out Agreements and (d) corrective action plans.

Section 4.09 Member Grievances/Appeals. Contracted Provider shall, and shall ensure its Providers, comply with the Program Policies, Laws and Program Requirements regarding Member grievances and appeals. Such compliance includes but is not limited to providing information, records or documents requested by CareOregon and participating in the grievance/appeal process.

Section 4.10 Compliance. In performing this Agreement, Contracted Provider shall, and shall require its Providers to, comply with all Laws and Program Requirements. Contracted Provider and its Providers shall (a) cooperate with CareOregon with respect to CareOregon's responsibilities under Laws or Program Requirements, and (b) not knowingly take any action contrary to CareOregon's obligations under Laws or Program Requirements.

(a) Privacy/HIPAA. Contracted Provider shall, and shall ensure its Providers, maintain Member information and medical records in accordance with Laws, including Federal and State Laws related to privacy and confidentiality of Member information and medical records, including HIPAA, and shall use and disclose such information or records only in accordance with Laws and Program Requirements.

(b) Fraud, Waste and Abuse. Contracted Provider shall, and shall ensure its Providers, comply with CMS program requirements and Laws designed to prevent or ameliorate fraud, waste, and abuse, including applicable provisions of Federal criminal law, the False Claims Act (31 USC §§ 3729, *et. seq.*), and the anti-kickback statute (Section 1128B(b) of the Social Security Act). In accordance with 42 CFR § 422.503(b)(4)(vi)(c) and 42 CFR § 423.504(b)(4)(vi)(c), Contracted Provider shall, and to the extent required by applicable law, shall require its subcontractors to, adopt and implement an effective compliance program, which must include measures that prevent, detect, and correct noncompliance with CMS program requirements as well as measures that prevent, detect, and correct fraud, waste and abuse. On an annual basis, an attestation satisfactory to CareOregon must be provided to CareOregon verifying that training and education in compliance and fraud, waste and abuse for Contracted Provider's employees, including the chief executive and senior administrators or managers; governing body members; and first tier, downstream, and related entities, has been conducted.

(c) Accreditation. Contracted Provider shall comply with policies and procedures required by CareOregon to obtain or maintain CareOregon's accreditation from accreditation bodies, including the National Committee for Quality Assurance or Utilization Review Accreditation Commission.

(d) Compliance Program/Reporting. OIG publishes compliance program guidance for health care firms available at <http://oig.hhs.gov/fraud/complianceguidance.asp>. Contracted Provider shall, and shall require its employees and, to the extent required by law its subcontractors and their employees to: (1) comply with CareOregon's compliance training requirements; and (2) report to CareOregon any suspected fraud, waste, or abuse or criminal acts by CareOregon, Payor, Contracted Provider, its Providers, their respective employees or subcontractors, or by Members. Reports may be made through www.ethicspoint.com or by calling 1-888-265-4068 (24 hours, 7 days a week), or such other vendor as CareOregon may designate by notice to Contracted Provider. Also, if DHHS publishes compliance program requirements that providers must follow as a condition of participation in Federal Health Care Programs, Contracted Provider shall, and to the extent required by law shall require its subcontractors to, comply with such requirements.

(e) Acknowledgement of Federal Funding. Claims, data and other information submitted by or on behalf of Contracted Provider to CareOregon or Payor pursuant to this Agreement may be used, directly or indirectly, for purposes of obtaining payments from Federal or State governments under Federal Health Care Programs, and payments that Contracted Provider receives under this Agreement may be, in whole or in part, from Federal funds.

(f) Certification of Data for Payment. Upon CareOregon's request, Contracted Provider shall submit certification by Contracted Provider, its Providers, or any Subcontracted Provider, stating that, based on Contracted Provider's, the Provider's, or the Subcontracted

Provider's best knowledge, information and belief, all data and other information directly or indirectly reported or submitted to CareOregon or Payor pursuant to this Agreement is accurate, complete and truthful.

(g) Exclusive Compensation. Contracted Provider shall not, and shall ensure its Providers do not, claim payment in any form, directly or indirectly, from a Federal Health Care Program for items or services covered under this Agreement, except for wrap around payments made directly by Governmental Authorities to certain qualified providers, such as Federally qualified health centers ("FQHCs") or rural health clinics ("RHCs"), where applicable.

(h) Ineligible Persons. Contracted Provider warrants and represents as of the Effective Date and throughout the Term and the duration of post expiration or termination transition activities described in this Agreement, that none of it, its Providers or any individual or entity it employs or has contracted with to carry out this Agreement is an Ineligible Person.

(i) Compliance Audit. CareOregon shall be entitled to audit Contracted Provider and its Providers with respect to Contracted Provider's performance of its duties and obligations hereunder and with respect to compliance issues, including their compliance programs, and require them to address compliance issues through education, counseling or corrective action plans. Contracted Provider shall, and shall ensure its Providers, cooperate with CareOregon with respect to any such audit, including by providing CareOregon with Records and site access within such time frames as requested by CareOregon.

(j) CCO Requirements. If the Benefit Plans include CCO plans, Contracted Provider shall comply with Exhibit B hereto setting forth the State of Oregon CCO subcontractor/provider requirements and shall require its Providers to comply therewith.

(k) Medicare Advantage Requirements. If the Benefit Plans include Medicare Advantage plans, Contracted Provider shall comply with Exhibit B hereto setting forth the federal Medicare Advantage subcontractor/provider requirements and shall require its Providers to comply therewith.

(l) Licensure. Contracted Provider shall secure and maintain all necessary licenses, certificates, permits, registrations, consents, approvals and authorizations that must be obtained by it to perform its obligations under this Agreement. As required by Program Requirements, Contracted Providers shall, and shall require its Providers to, meet the conditions of participation and be enrolled in applicable Federal Health Care Programs (including for dual eligible special needs plan Members, both Medicare and Medicaid) and have all licenses and accreditations necessary to meet such conditions of participation.

Section 4.11 Insurance. Contracted Provider and its Providers shall secure and maintain for themselves and their employees, commercial general liability and professional liability (malpractice) insurance or self-insurance coverage for claims arising out of events occurring during the Term and any post expiration or termination activities under this Agreement, in amounts required to meet Credentialing Criteria, and workers' compensation insurance as required by State Laws. Contracted Provider and its Providers shall, upon request of CareOregon, provide CareOregon with certificates of insurance or other evidence of coverage

reflecting satisfaction of the foregoing requirements of this paragraph. Contracted Provider and its Providers shall provide at least 30 days' prior notice to CareOregon in advance of any material modification, cancellation or termination of their insurance.

Section 4.12 Proprietary Information. In connection with this Agreement, Contracted Provider may obtain from CareOregon, its Affiliates, or Payors, directly or indirectly, certain information that CareOregon or its Affiliates or Payors have: (1) taken reasonable measures to maintain as confidential and that is not being generally known or readily ascertainable by the public or (2) has marked as confidential or proprietary ("**Proprietary Information**"). Proprietary Information includes, but is not limited to, Member lists, the compensation provisions of this Agreement and other information relating to CareOregon's or its Affiliates' or Payors' business that is not generally available to the public. Contracted Provider shall, and shall require its employees, agents and subcontractors to, hold in confidence and not disclose any Proprietary Information and not use Proprietary Information except (a) as expressly permitted under this Agreement, or (b) as required by Laws or legal or regulatory process. Contracted Provider shall, and shall require its employees, agents and subcontractors to, provide CareOregon with prior notice of any such disclosure required by Laws or legal or regulatory process so that CareOregon can seek an appropriate protective order. Contracted Provider shall, and shall require its employees, agents and subcontractors to, disclose Proprietary Information only in order to perform their obligations under this Agreement, and only to persons who have agreed to maintain the confidentiality of the Proprietary Information. The requirements of this Agreement regarding Proprietary Information shall survive expiration or termination of this Agreement.

Section 4.13 Required Notices. In addition to any other notices required under this Agreement, Contracted Provider shall give notice to CareOregon within two business days of the occurrence of any event that could reasonably be expected to impair the ability of Contracted Provider or any Provider to comply with the obligations of this Agreement, including any of the following with respect to Contracted Provider or any of its Providers: (a) an occurrence that causes any of the representations and warranties in this Agreement to be inaccurate; (b) failure to maintain insurance as required by this Agreement; (c) a license, certification or accreditation expires or is suspended, revoked, conditioned or otherwise restricted; (d) exclusion, suspension or debarment from, or imposition of sanction under a Federal Health Care Program; (e) a disciplinary action is initiated by a Governmental Authority; (f) hospital privileges are suspended, limited, revoked or terminated; (g) a grievance or legal action is filed by a Member; (h) investigation for fraud or a felony; or (i) a settlement related to any of the foregoing is entered by Provider or Contracted Provider.

Section 4.14 Indemnification. Except to the extent prohibited by applicable law Contracted Provider shall indemnify and hold CareOregon harmless from any and all liability, damages, costs and expenses, including reasonable attorney's fees, that CareOregon or its officers, employees or agents become obligated to pay due to the negligent or intentional acts or omissions of Covered Provider or any of its officers, employees or agents arising out of Covered Provider's duties and obligations under this Agreement, provided that no indemnification will be required to the extent it would result in the loss of available coverage under the liability insurance maintained by Participating Provider. In the event Covered Provider is a public body pursuant to the Oregon Tort Claims Act, then Covered Provider's indemnification obligation

hereunder shall be subject to the applicable enforceable limits of the Oregon Tort Claims Act and in accordance with the Oregon Constitution. Except to the extent prohibited by applicable law CareOregon shall indemnify and hold Contracted Provider harmless from any and all liability, damages, costs and expenses, including reasonable attorney's fees, that Contracted Provider or its officers, employees or agents become obligated to pay due to the negligent or intentional acts or omissions of CareOregon or any of its officers, employees or agents arising out of CareOregon's duties and obligations under this Agreement, provided that no indemnification will be required to the extent it would result in the loss of available coverage under the liability insurance maintained by Participating Provider. The parties acknowledge that state and federal agencies may review and audit all contracts, claims, bills and other expenditures of Medicare, Medicaid, and other medical assistance program funds, to determine compliance. Covered Provider agrees to indemnify and hold harmless CareOregon from any and all liability arising out of any suit, investigation, administrative action, fine, penalty or sanction by such state or federal agencies against CareOregon arising from negligent or wrongful actions of the Covered Provider, its officers, agents or employees. CareOregon agrees to indemnify and hold harmless Covered Provider from any and all liability arising out of any suit, investigation, administrative action, fine, penalty or sanction by such state or federal agencies against Covered Provider arising from negligent or wrongful actions of the CareOregon, its officers, agents or employees. This Section 4.14 shall survive the termination or expiration of this Agreement.

ARTICLE V. CAREOREGON RESPONSIBILITIES

Section 5.01 ID Cards. CareOregon shall cause to be issued identification cards, or the functional equivalent thereof, to Members and instruct them to present their cards or equivalent to providers when seeking health care items and services.

Section 5.02 Claims Processing. Payor shall pay or deny Clean Claims by the forty-fifth (45th) day after CareOregon receives a Clean Claim, or such earlier time as is required by Laws. Payor may use claims editing software programs to assist it in determining proper coding for Contracted Provider claims hereunder. Such software programs use industry standard coding criteria and incorporate guidelines established by CMS such as the National Correct Coding Initiative and the National Physician Fee Exhibit Database, the AMA and Specialty Society correct coding guidelines, and state specific regulations. These software programs may result in claim edits for specific procedure code combinations.

Section 5.03 Compensation. Compensation to Contracted Provider for Covered Services hereunder shall be as set forth in **Exhibit C** subject to any adjustments called for in the payment provisions of this Agreement including without limitation provisions pertaining to recoupment of overpayment, coordination of benefits, and prior authorization. Exhibit C may be amended or replaced pursuant to the notice provisions of Paragraph 8.14. Covered Provider shall accept such compensation (plus wrap around payments from Governmental Authorities to qualified providers such as FQHCs or RHCs, where applicable) as payment in full for Covered Services rendered to Members and all other activities of Covered Provider and its Providers under this Agreement. Contracted Provider shall not receive payment for items and services constituting Never Events or Non-Contracted Services. Any claim for payment by Contracted Provider hereunder shall be brought within one year after the payment obligation arose or such claim shall be time barred.

Section 5.04 Medical Record Review. CareOregon or Payor may perform concurrent or retrospective reviews of medical records for utilization management purposes or to verify that items and services billed to or paid for were provided and billed correctly in accordance with this Agreement and the Program Policies, or were Covered Services (including that such items and services were Medically Necessary) and Contracted Provider shall, and shall ensure its Providers, cooperate in such review.

Section 5.05 Recoupment of Overpayments. Unless otherwise prohibited by Laws, Contracted Provider, for itself and its Providers, authorizes Payor to deduct from amounts that may otherwise be due and payable to Contracted Provider any outstanding amounts that Contracted Provider may owe Payor for any reason, including Overpayments, in accordance with its recoupment policy and procedure; “**Overpayment**” for purposes of this Agreement means any funds that Contracted Provider or its Provider receives or retains to which Contracted Provider or its Provider is not entitled, including overpayments (a) for items and services later determined not to be Covered Services, (b) due to erroneous or excess reimbursement, (c) resulting from errors and omissions relating to changes in enrollment, claims payment errors, data entry errors or incorrectly submitted claims, or (d) for claims paid when Payor was the secondary payor and the Provider should have been reimbursed by the primary payor. An Overpayment also includes any payment Payor makes that is the obligation of and not paid by a Provider, including for improperly collected Member Expenses due a Member. If there are no payments to offset, or otherwise upon request of Payor, Contracted Provider shall repay Overpayments to Payor within 30 days, or such other time frame as may be mandated by Laws or Program Requirements, of the Contracted Provider’s receipt of notice of such Overpayment. Notwithstanding anything in this paragraph 5.05 to the contrary; however, such deduction or demand for payment may occur only as to Overpayments made within a one-year period prior to the date of deduction or demand. This paragraph shall survive expiration or termination of this Agreement.

Section 5.06 Suspension of Payment. If DHHS suspends payments to Contracted Provider or any of its Providers while Governmental Authorities investigate an allegation of fraud, then Payor may suspend the Provider and payments for Covered Services provided by the Provider during the period of the DHHS suspension of payments.

Section 5.07 Retained or Delegated Functions. To the extent allowed by Law, CareOregon may delegate functions related to Benefit Plan management to third parties or to Payor. Alternatively Payor may retain certain functions in administering the Benefit Plan. Examples of functions that may be performed by CareOregon, Payor or a third party, depending upon the specific Benefit Plan include for example, issuing Member identification cards or the equivalent, credentialing, administration of Member or Provider grievances and appeals, quality improvement, auditing, billing, inspection, monitoring, prior authorizations, utilization review, and case management. In instances where CareOregon delegates functions to Payor or another third party or Payor retains certain functions, CareOregon shall notify Contracted Provider in writing of such delegation or retention of the function and Contracted Provider shall cooperate with the CareOregon designee in performing functions or duties hereunder to the same extent that Contracted Provider is required to cooperate with CareOregon hereunder in performing such functions and duties.

Section 5.08 CareOregon License. CareOregon is and will remain properly licensed and/or accredited in accordance with Laws.

Section 5.09 Insurance. CareOregon shall maintain such policies of general and professional liability insurance in accordance with Laws and to insure CareOregon against claims regarding CareOregon operations and performance under this Agreement.

ARTICLE VI. RECORDS; ACCESS; AUDITS

Section 6.01 Maintenance. Contracted Provider shall, and shall cause its subcontractors to, maintain operational, financial and administrative records, contracts, books, files, data and other documentation related to the Covered Services provided to Members, claims filed and other services and activities conducted under this Agreement (“**Records**”). Contracted Provider shall ensure that such Records are kept in accordance with Laws, Program Requirements, generally accepted accounting principles (as applicable) and prudent record keeping practices and are sufficient to enable CareOregon to enforce its rights under this Agreement, including this paragraph, and to determine whether Contracted Provider and its subcontractors and their respective employees are performing or have performed Contracted Provider’s obligations in accordance with this Agreement, Laws and Program Requirements. Contracted Provider shall, and shall cause its subcontractors to, maintain such Records for the time period set forth in the applicable Program Attachment governing the Benefit Plan. Records that are under review or audit shall be retained until the completion of such review or audit if that date is later than the time frame indicated above.

Section 6.02 Access and Audit. CareOregon shall have the right to monitor, inspect, evaluate and audit Contracted Provider and its Providers and subcontractors as necessary to comply with Laws or Program Requirements or to verify Contracted Provider’s compliance with and satisfactory performance of, this Agreement. In connection with any monitoring, inspection, evaluation or audit, Contracted Provider shall, and shall cause its Providers and subcontractors to, at no additional cost to CareOregon, provide CareOregon with access to all Records, personnel, physical facilities, equipment and other information necessary for CareOregon or its auditors to conduct the audit. Within three business days of CareOregon’s written request for Records, or such shorter time period required for CareOregon to comply with requests of Governmental Authorities, Contracted Provider shall, and shall cause its Providers and subcontractors to, compile and prepare all such Records and furnish such Records to CareOregon in a form as reasonably requested by CareOregon. CareOregon shall pay the reasonable copying cost, which shall include only the direct cost of copying and not the cost of personnel used in gathering the records and arranging for copying. Contracted Provider shall provide CareOregon with an estimate of such costs and obtain CareOregon consent prior to copying such records. In CareOregon’s discretion, rather than pay the direct cost of the copies, CareOregon may arrange for copies to be made at its own expense.

Section 6.03 Survival. The requirements of this Agreement regarding Records, access, inspection, and audit shall survive expiration or termination of this Agreement.

**ARTICLE VII.
TERM AND TERMINATION**

Section 7.01 Term. The term of this Agreement (the “**Term**”) shall begin on the Effective Date and continue for a period of one year, and thereafter shall renew for successive periods of one year each unless a Party provides notice of nonrenewal to the other at least 90 days before the end of the then current (initial or renewal) term, unless and until the Agreement is terminated in accordance with the terms and conditions of the Agreement, including those in a Program Attachment.

Section 7.02 Termination

(a) Termination Without Cause. Either Party may terminate this Agreement, in whole or with respect to any particular Program or Benefit Plan, at any time upon 90 days’ prior notice to the other. CareOregon may terminate this Agreement as to any particular Provider at any time for any reason or no reason upon 90 days’ prior notice to Contracted Provider.

(b) Termination for Cause.

(i) A Party may terminate this Agreement for material breach of this Agreement by the other Party by providing the other Party at least 90 days’ prior written notice specifying the nature of the material breach, and no cure having been made during the first 60 days of the notice period.

(ii) CareOregon may terminate this Agreement as to a particular Provider for a material failure by the Provider to comply with any of the terms or provisions of this Agreement by providing Contracted Provider at least 90 days’ prior notice specifying the nature of the material failure, no cure having been made to CareOregon’s satisfaction during the first 60 days of the notice period. Upon termination by CareOregon of a Provider, Contracted Provider shall remove Provider from performing any of the services hereunder.

(c) Immediate Termination. CareOregon may terminate this Agreement in its entirety, or with respect to a particular Provider, upon immediate notice to Contracted Provider upon the occurrence of any of the following: (a) termination is necessary for health and safety of one or more Members; (b) a Provider suffers the loss, suspension or restriction of a license from a Governmental Authority or accreditation from an accreditation body required to carry out its obligations under this Agreement, including meeting the conditions of participation in applicable Programs; (c) Covered Provider or any of its Providers becomes an Ineligible Person or voluntarily withdraws from participation in applicable Programs, and is not immediately terminated by Contracted Provider; (d) a Governmental Authority orders CareOregon to terminate the Agreement; (e) CareOregon reasonably determines or a Governmental Authority determines or advises that a Provider or Contracted Provider is engaging or has engaged in fraud or abuse, or has submitted a false claim; (f) a Provider fails to meet Credentialing Criteria; (g) a Provider or Contracted Provider fails to maintain insurance as required by this Agreement; (h) a Provider or Contracted Provider undergoes a change of control that is not acceptable to CareOregon; or (i) Contracted Provider becomes insolvent, is adjudicated as bankrupt, has its

business come into possession or control of any trustee in bankruptcy, has a receiver appointed for it, or makes a general assignment for the benefit of its creditors.

(d) **Transition of Care.** To ensure that a transition is undertaken in an orderly manner that maximizes Member safety and continuity of care, upon expiration or termination of this Agreement for any reason upon request of CareOregon, Contracted Provider shall continue to provide care and assist in transitioning Members to new providers in accordance with Laws and Program Requirements (“**Transitional Care**”). Such Transitional Care requirements may include, for example, that care for certain chronic or acute conditions continue for 90 days after the end of the Term and that post-partum care be provided after the end of the Term for Members in their second or third trimester as of the date the Term ended. The terms and conditions of this Agreement shall apply to Transitional Care after the Term, provided that notwithstanding any compensation provisions of this Agreement, Contracted Provider shall be paid for such transitional services provided after the Term at 100 percent of Payor’s then current rate schedule for the applicable Benefit Plan. The Transitional Care provisions in this paragraph shall survive expiration or termination of this Agreement.

(e) **Notification to Members.** Upon expiration or termination of this Agreement, CareOregon will communicate such expiration or termination to Members as required by and in accordance with Laws and Program Requirements. Contracted Provider shall obtain CareOregon’s prior written approval of Provider communications to Members regarding the expiration or termination of this Agreement. The foregoing sentence shall not prevent a Provider from engaging in communications with his patient regarding the patient’s health.

ARTICLE VIII. DISPUTE RESOLUTION

Section 8.01 Provider Administrative Review and Appeals. Where applicable, a Provider or Contracted Provider shall exhaust all CareOregon or Payor review and appeal rights regarding provider disputes in accordance with the Program Policies before seeking any other remedy. Where required by Laws or Program Requirements, administrative reviews and appeals shall be subject to and resolved in accordance with applicable administrative law.

Section 8.02 Disputes. Disputes between CareOregon and a Provider or Contracted Provider related to this Agreement must be submitted to arbitration within one year of the act or omission giving rise to the claim or dispute. The failure to initiate arbitration within the foregoing time period will constitute waiver of such claims and disputes.

Section 8.03 Dispute Resolution. Before a Party initiates arbitration regarding a claim or dispute under this Agreement (a “**Dispute**”), the Parties shall meet and confer in good faith to seek resolution of the Dispute. If a Party desires to initiate the procedures under this paragraph, the Party shall give notice (a “**Dispute Initiation Notice**”) to the other Party providing a brief description of the nature of the Dispute, explaining the initiating Party’s claim or position in connection with the Dispute, including relevant documentation, and naming an individual with authority to settle the Dispute on such Party’s behalf. Within 20 days after receipt of a Dispute Initiation Notice, the receiving Party shall give a written reply (a “**Dispute Reply**”) to the initiating Party providing a brief description of the receiving Party’s position in connection with

the Dispute, including relevant documentation, and naming an individual with the authority to settle the Dispute on behalf of the receiving Party. The Parties shall promptly make an investigation of the Dispute, and commence discussions concerning resolution of the Dispute within 20 days after the date of the Dispute Reply. If a Dispute has not been resolved within 30 days after the Parties have commenced discussions regarding the Dispute, either Party may submit the dispute to arbitration subject to the terms and conditions herein. Failure to comply with this paragraph shall not bar a party from submitting the Dispute to arbitration; however, a Party's failure to take advantage of this informal process may be considered by the arbitrator in making any award of attorneys' fees hereunder.

Section 8.04 Arbitration. Except as barred or excepted by this Agreement, all claims and disputes between the Parties shall be resolved exclusively by final, binding and confidential arbitration in Multnomah County, Oregon. The arbitration shall be conducted using the rules and under the auspices of the Arbitration Service of Portland ("ASP"). The arbitration shall be held before a single arbitrator, unless the amount in dispute is more than \$10 million, in which case it will be held before a panel of three arbitrators. In a case with a single arbitrator, the Parties shall select the arbitrator by agreement within 30 days of the date the Demand for Arbitration is filed, and if the Parties are unable to agree on the selection of an arbitrator within such time, ASP shall select an independent arbitrator. In the case of a panel, each Party shall select an arbitrator, and the two arbitrators shall select the third arbitrator, and if the two arbitrators are unable to agree on the selection of a third arbitrator within thirty days after arbitration is initiated, ASP shall select an independent third arbitrator. The arbitrator or panel may not certify a class or conduct class based arbitration. The decision of the arbitrator or panel shall be final and binding on the Parties. The award of the arbitrator or panel may be confirmed or enforced in any court having jurisdiction. Except as otherwise provided in this Agreement, each Party shall bear its own costs related to the arbitration, including costs of subpoenas, depositions, transcripts, witness fees, and attorneys' fees and the compensation and expenses of the arbitrator and administrative fees or costs of the arbitration shall be borne equally by the Parties.

Section 8.05 Damages Limitation. In no event shall CareOregon be liable to Contracted Provider for any incidental, indirect, special, consequential or emotional distress damages of any kind.

Section 8.06 Governing Law/Venue. This Agreement shall be governed by and construed and enforced in accordance with the laws of the state of Oregon, without regard to principles of conflict of laws. Each of the Parties hereby agrees and consents to be subject to the exclusive jurisdiction and venue of the appropriate state or federal court located in Multnomah County Oregon, in any suit, action, or proceeding seeking to enforce any provision of, or based on any matter arising out of or in connection with, this Agreement that is not subject to arbitration.

Section 8.07 Waiver of Jury Trial. Each Party hereby irrevocably and unconditionally waives, to the fullest extent it may legally and effectively do so, trial by jury in any suit, action or proceeding arising hereunder.

Section 8.08 Equitable Relief. Notwithstanding anything in this Agreement to the contrary, either Party may bring court proceedings to seek temporary or preliminary injunctive relief to enforce any right, duty or obligation under this Agreement.

Section 8.09 Independent Contractors. The Parties are independent contractors. This Agreement shall not be deemed to create a partnership or joint venture, or an employment or agency relationship between the Parties. Neither Party has the right nor the authority to assume or create any obligation or responsibility on behalf of the other. Neither Party is liable for the acts of the other.

Section 8.10 No Steering. For the Term and for one year thereafter, Contracted Provider shall not, and shall ensure that its Providers do not, engage in steering or otherwise directly or indirectly solicit any Member to cease or reduce its business with CareOregon or any Benefit Plan.

Section 8.11 Third Parties. Except as otherwise provided in this Agreement, this Agreement is not a third party beneficiary contract and no provision of this Agreement is intended to create or may be construed to create any third party beneficiary rights in any third party, including any Member or any Provider.

Section 8.12 Notices. Except for non-material revisions to the Program Policies, all notices required or permitted under this Agreement must be in writing and sent by (a) hand delivery, (b) U.S. certified mail, postage prepaid, return receipt requested, (c) overnight delivery service providing proof of receipt, (d) facsimile or (e) email, to the addresses of the Parties as set forth on the signature page. Each Party may designate by notice any future or different addresses to which notices will be sent. Notices will be deemed delivered upon receipt or refusal to accept delivery. Notice to Contracted Provider shall constitute notice to its Providers.

Section 8.13 Incorporation of Laws/Program Requirements/Accreditation Standards. All terms and conditions of this Agreement are subject to Laws, Program Requirements and accreditation standards. Any term, condition or provision now or hereafter required to be included in the Agreement by Laws, Program Requirements or accreditation standards shall be deemed incorporated herein and binding upon and enforceable against the Parties, regardless of whether or not the term, condition or provision is expressly stated in this Agreement. CareOregon may amend this Agreement upon notice to Contracted Provider to comply with Laws, Program Requirements or accreditation standards, and such amendment shall be effective upon receipt or such other date indicated on the amendment.

Section 8.14 Amendment. Except as otherwise stated in this paragraph, this Agreement and its Exhibits may only be modified in writing and signed by the authorized parties hereto. Notwithstanding the foregoing: (a) CareOregon may amend this Agreement, and its Exhibits, upon thirty (30) days' written notice to Contracted Provider and such amendments shall automatically become effective thirty-one (31) days after the date of written notice, unless written notice rejecting such amendments is delivered to CareOregon by Contracted Provider within thirty (30) days, in which case CareOregon may terminate this Agreement for convenience in accordance with this Agreement; (b) CareOregon may make Non-Material Changes to the Exhibits effective immediately upon notice (or effective on such later date specified in the notice) to Contracted Provider ("**Non-Material Changes**" shall mean routine updates to CPT or other nationally recognized codes (for example, codes are replaced, retired, or split into two codes), and other changes that do not have a material impact on Contracted Provider's continued ability to render Covered Services to Members); and (c) CareOregon may

make amendments to the Agreement or Exhibits that are necessary to comply with Laws or Government Contracts effective immediately upon notice to Contracted Provider (or effective on such later date specified in the notice).

Section 8.15 Assignment. Contracted Provider may not assign, delegate or transfer this Agreement, in whole or in part, without the prior written consent of CareOregon. CareOregon may assign this Agreement, in whole or in part, to any of its Affiliates or to the purchaser of the assets or successor to the operations of CareOregon or its Affiliates.

Section 8.16 Name, Symbol and Service Mark. The Parties shall not use each other's name, symbol, logo, or service mark for any purpose without the prior written approval of the other. Notwithstanding the foregoing: (a) Covered Provider and its Providers may include CareOregon's or Benefit Plan names in listings of health plans Covered Provider and its Providers participate in, and (b) CareOregon or Payors may use information about Covered Provider and its Providers in information or publications identifying Participating Providers or as required by Laws or Program Requirements. Covered Provider shall, and shall require its Providers to, provide comparable treatment to CareOregon and Payors as they provide to other managed care organizations or private insurers with respect to marketing or the display of cards, plaques or other logos supplied by CareOregon or Payor to inform Members that Providers are Participating Providers under the Benefit Plans.

Section 8.17 Other Agreements. If a Provider participates as a Participating Provider under more than one agreement with CareOregon or Payor for a particular Program, CareOregon or Payor will compensate the Provider for Covered Services it provides to Members of Benefit Plans in that Program under the agreement selected by CareOregon or Payor.

Section 8.18 Force Majeure. Each Party shall have and maintain disaster recovery plans in accordance with industry standards. However, if either Party's performance under this Agreement is prevented, hindered or delayed by reason of any cause beyond the Party's reasonable control that cannot be overcome by reasonable diligence, including war, acts of terrorism, civil disorders, labor disputes (other than strikes within such Party's own labor force), governmental acts, epidemics, quarantines, embargoes, fires, earthquakes, storms, or acts of God, such Party shall be excused from performance to the extent that it is prevented, hindered or delayed thereby, during the continuances of such cause; and such Party's obligations hereunder shall be excused so long as and to the extent that such cause prevents or delays performance. If Covered Provider is unable to perform under this Agreement due to an event as described in this paragraph, CareOregon may take whatever action is reasonable and necessary under the circumstances to ensure its compliance with Laws and Program Requirements and equitably adjust payments to Covered Provider until Covered Provider resumes its performance under this Agreement.

Section 8.19 Severability. When possible, each provision of this Agreement shall be interpreted in such a manner as to be effective, valid and enforceable under Laws. If any provision of this Agreement is held to be prohibited by, or invalid or unenforceable under Laws, such provision shall be ineffective only to the express extent of such prohibition, unenforceability or invalidity, without invalidating the remainder of this Agreement.

Section 8.20 Waiver. No waiver shall be effective unless in writing and signed by the waiving Party. A waiver by a Party of a breach or failure to perform this Agreement shall not constitute a waiver of any subsequent breach or failure.

Section 8.21 Entire Agreement. This Agreement, including the Exhibits, each of which are made a part of and incorporated into this Agreement, comprises the complete agreement between the Parties and supersedes all previous agreements and understandings (whether verbal or in writing) related to the subject matter of this Agreement.

Section 8.22 Headings. The various headings of this Agreement are provided for convenience only and shall not affect the meaning or interpretation of this Agreement or any provision of it.

Section 8.23 Interpretation. Both Parties have had the opportunity to review this Agreement with legal counsel, and any ambiguity found in this Agreement shall not be construed in a Party's favor on the basis that the other Party drafted the provision containing the ambiguity.

Section 8.24 Survival. Any provision of this Agreement, including any Exhibit, that requires or reasonably contemplates the performance or existence of obligations by a Party after expiration or termination of this Agreement shall survive such expiration or termination regardless of the reason for expiration or termination.

Section 8.25 Rights Cumulative. Except as set forth herein, all rights and remedies of a Party in this Agreement are cumulative, and in addition to all legal rights and remedies available to such Party.

Section 8.26 Counterparts/Electronic Signatures. This Agreement may be executed in any number of counterparts. The exchange of copies of this Agreement and of signature pages by facsimile transmission or electronic mail shall constitute effective execution and delivery of this Agreement as to the parties and may be used in lieu of the original Agreement for all purposes.

Section 8.27 Warranties and Representations. Each Party warrants and represents, as of the Effective Date and continuously thereafter throughout the entire Term and during the post expiration or termination transition period described herein, as follows:

(a) The Party is a corporation or other legally recognized entity duly incorporated or organized, validly existing and in good standing under the laws of the State in which it is incorporated, organized or operating, and it has the authority to transact business in each State in which it operates.

(b) The Party has the corporate or company power and legal authority to, and has taken all necessary corporate or other action on its part to, authorize the execution and delivery of this Agreement and the performance of its obligations hereunder.

(c) This Agreement has been duly executed and delivered by the Party, and constitutes a legal, valid, and binding agreement that is enforceable against such Party in accordance with its terms.

(d) The execution and delivery of this Agreement and the performance of the Party's obligations hereunder do not (a) conflict with or violate any provision of the Party's organizational documents or Laws, or (b) conflict with, or constitute a default under, any contractual obligation of the Party.

SIGNATURE PAGE

IN WITNESS WHEREOF, the undersigned, with the intent to be legally bound, have caused this Agreement to be duly executed and effective as of the Effective Date.

CAREOREGON, INC.

CLACKAMAS COUNTY COMMUNITY HEALTH DIVISION

Signature: _____

Signature: _____

Name: Scott Clement

Name: _____

Title: Chief Network Officer

Title: _____

Date: _____

Date: _____

Tax ID: _____

CareOregon Notice Address:

Contracted Provider Notice Address:

Attention: Chief Network Officer
CareOregon, Inc.
315 SW Fifth Avenue Suite 900
Portland, OR 97204

Attention: Administrator
Clackamas County Commission Health Division
2051 Kaen Road
Oregon City, OR 97045

**EXHIBIT A
LIST OF APPLICABLE BENEFIT PLANS**

Effective Date:

Oregon Health Plan

Oregon Health Plan (OHP)

Medicare Plans

CareOregon Medicare Advantage Plus

CareOregon Advantage Star

Coordinated Care Organizations

CCOs with a CareOregon Payor Arrangement

Columbia Pacific CCO, LLC

Jackson County CCO, LLC, DBA Jackson Care Connect

Tri-County Medicaid Collaborative, DBA Health Share of Oregon (physical health services only)

CCOs with a CCO Payor Arrangement

Yamhill County Care Organization, Inc.

Private Insurance Plans

None.

This Exhibit is effective as of the date indicated above and supersedes any prior Exhibit A and may be amended or replaced pursuant to paragraph 8.14 of the Provider Agreement.

**EXHIBIT B
PROGRAM ATTACHMENT**

CCO CONTRACT PROVISIONS APPLICABLE TO SUBCONTRACTORS

Provider (“Subcontractor”) has agreed to provide services to one or more Coordinated Care Organizations (“CCOs”) pursuant to a Health Plan Services Contract entered into by the CCO (also referred to herein as “Contractor”) and the State of Oregon, acting by and through its Oregon Health Authority (“OHA”), Division of Medical Assistance Programs (“DMAP”) to provide and pay for Coordinated Care Services (the “CCO Contract”).

The CCO Contract requires that the provisions in this Exhibit be included in any subcontracts and contracts with Participating Providers. This Exhibit is incorporated by reference into and made part of the Professional Services Agreement (the “Agreement”) with respect to goods and services rendered under the Agreement by Provider to CCO enrollees who are enrolled in the Oregon Health Plan Medicaid managed care program (“Members”). In the event of a conflict or inconsistency with any term or condition in the Agreement, this Exhibit shall control.

Subcontractor shall comply with the provisions in this Exhibit to the extent that they are applicable to the goods and services provided by Subcontractor under the Agreement; provided, however, that the Agreement shall not terminate or limit Contractor’s legal responsibilities to OHA for the timely and effective performance of Contractor’s duties and responsibilities under the CCO Contract. Capitalized terms used in this Exhibit, but not otherwise defined in the Agreement shall have the same meaning as those terms in the CCO Contract, including definitions incorporated therein by reference.

1. OHA. To the extent any provision in the CCO Contract applies to Contractor with respect to the Work Contractor is providing to OHA through the Agreement, that provision shall be incorporated by reference into the Agreement and shall apply equally to Subcontractor.

2. Termination for Cause. In addition to pursuing any other remedies allowed at law or in equity or by the Agreement, the Agreement may be terminated by Contractor, or Contractor may impose other sanctions against Subcontractor, if the Subcontractor’s performance is inadequate to meet the requirements of the CCO Contract.

3. Monitoring.

3.1. *By Contractor*. Contractor will monitor the Subcontractor’s performance on an ongoing basis and perform at least once a year a formal review of compliance with delegated responsibilities and Subcontractor’s performance, deficiencies or areas for improvement, in accordance with 42 CFR 438.230. Upon identification of deficiencies or areas for improvement, Subcontractor shall take the Corrective Action identified by Contractor.

3.2. *By OHA*. Subcontractor agrees that OHA is authorized to monitor compliance with the requirements in the Statement of Work under the CCO Contract and that methods of monitoring compliance may include review of documents submitted by Subcontractor, CCO Contract performance review, Grievances, on-site review of documentation or any other source of relevant information. Subcontractor shall cooperate in making records and facilities available for such review.

4. Federal Medicaid Managed Care. Subcontractor shall comply with the requirements of 42 CFR §438.6 that are applicable to the Work required under the Agreement.

5. Hold Harmless. Subcontractor shall not hold OHA nor a Member receiving services liable for any costs or charges related to Contractor-authorized Covered Services rendered to a Member whether in an emergency or otherwise. Furthermore, Subcontractor shall not hold a Member liable for any payments for any of the following: (a) Contractor's or Subcontractor's debt due to Contractor's or Subcontractor's insolvency; (b) Coordinated Care Services authorized or required to be provided under the CCO Contract and the Agreement to a Member, for which (i) OHA does not pay Contractor; or (ii) Contractor does not pay Subcontractor for Covered Services rendered to a Member as set forth in the Agreement; and (c) Covered Services furnished pursuant to the Agreement to the extent that those payments are in excess of the amount that the Member would owe if Contractor provided the services directly. Subcontractor may not initiate or maintain a civil action against a Member to collect any amounts owed by the Contractor for which the Member is not liable to the Subcontractor under the Agreement. Nothing in this paragraph 5 shall impair the right of the Subcontractor to charge, collect from, attempt to collect from or maintain a civil action against a Member for any of the following: (a) deductible, copayment, or coinsurance amounts, (b) health services not covered by the Contractor or the OHP Contract, and (c) health services rendered after the termination of the Agreement, unless the health services were rendered during the confinement in an inpatient facility and the confinement began prior to the date of termination of the Agreement or unless the Subcontractor has assumed post-termination treatment obligations under the Agreement.

6. Continuation. Subcontractor shall continue to provide Covered Services during periods of Contractor insolvency or cessation of operations through the period for which CCO Payments were made to Contractor.

7. Billing and Payment. Subcontractor shall not bill Members for services that are not covered under the CCO Contract unless there is a full written disclosure or waiver on file signed by the Member, in advance of the service being provided, in accordance with OAR 410-141-0420.

8. Reports. Subcontractor shall provide timely access to records and facilities and cooperate with OHA 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 the CCO Contract, including but not limited to verification of services actually provided, and for developing and monitoring performance and outcomes.

9. Quality Improvement. In conformance with 42 CFR 438 Subpart E, Subcontractor shall cooperate with OHA 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 the CCO Contract.

10. Access to Records. Subcontractor shall maintain all financial records related to the CCO Contract in accordance with generally accepted accounting principles or National Association of Insurance Commissioners accounting standards. In addition, Subcontractor shall maintain any other records, books, documents, papers, plans, records of shipment and payments and writings of Subcontractor, whether in paper, electronic or other form, that are pertinent to the CCO Contract (the "Records") in such a manner to clearly document Subcontractor's performance. Subcontractor shall provide timely and reasonable access to Records to: (a) OHA; (b) the Secretary of State's Office; (c) CMS; (d) the Comptroller General of the United States; (e) the Oregon Department of Justice Medicaid Fraud Control Unit; and (g) all their duly authorized representatives, to perform examinations and audits, make excerpts and transcripts, and evaluate the quality, appropriateness and timeliness of services performed. Subcontractor shall, upon request and without charge, provide a suitable work area and copying capabilities to facilities for such a review or audit. Subcontractor shall retain and keep accessible all Records for the longer of: (a) six years following final payment and termination of the CCO Contract; (b) the period as may be required by applicable law, including the records retention schedules set forth in

OAR Chapter 166; or (c) until the conclusion of any audit, controversy or litigation arising out of or related to the CCO Contract. The rights of access in this paragraph 10 are not limited to the required retention period, but shall last as long as the Records are retained.

11. Clinical Records and Confidentiality of Member Records. Subcontractor shall comply with Contractor's policies and procedures that ensure maintenance of a record keeping system that includes maintaining the security of records as required by the Health Insurance Portability and Accountability Act, 42 USC 1320d et. seq., and the federal regulations implementing the Act ("HIPAA"), and complete Clinical Records that document the Coordinated Care Services received by the Members. Contractor shall regularly monitor Subcontractor's compliance with these policies and procedures and Subcontractor shall be subject to and comply with any Corrective Action taken by Contractor that is necessary to ensure Subcontractor compliance.

12. Reporting of Abuse. Subcontractor shall comply with all patient abuse reporting requirements and fully cooperate with the State for purposes of ORS 410.610 et.seq., ORS 419B.010 et.seq., ORS 430.735 et.seq., ORS 433.705 et.seq., ORS 441.630 et.seq., and all applicable Administrative Rules. In addition, Subcontractor shall comply with all protective services, investigation and reporting requirements described in OAR 943-045-0250 through 943-045-0370 and ORS 430.735 through 430.765.

13. Fraud and Abuse. Subcontractor shall comply with Contractor's fraud and Abuse policies to prevent and detect fraud and Abuse activities as such activities relate to the OHP, and shall promptly refer all suspected cases of fraud and Abuse to the Contractor and the Medicaid Fraud Control Unit ("MFCU"). Subcontractor shall permit the MFCU or OHA or both to inspect, evaluate, or audit books, records, documents, files, accounts, and facilities maintained by or on behalf of Subcontractor, as required to investigate an incident of fraud and Abuse. Subcontractor shall cooperate with the MFCU and OHA investigator during any investigation of fraud and Abuse. Subcontractor shall provide copies of reports or other documentation regarding any suspected fraud at no cost to MFCU or OHA during an investigation.

14. Certification. Subcontractor certifies that all Claims data submissions by the Subcontractor, either directly or through a third party submitter, is and will be accurate, truthful and complete in accordance with OAR 410-141-3320 and OAR 410-120-1280.

15. Mental Health Services and Substance Use Disorder Services.

15.1. *Measures and Outcomes Tracking System.* If Subcontractor provides Mental Health Services and/or substance use disorder services, Subcontractor must enroll all individuals receiving services and maintain those individual's records in the Measure and Outcomes Tracking System (MOTS) as specified in OHA's MOTS Reference Manual located at: <http://www.oregon.gov/OHA/amh/mots/Pages/resource.aspx> and as it may be revised from time to time.

15.2. *Community Services.* If Subcontractor provides substance use disorder services, Subcontractor shall provide to Members, to the extent of available community resources and as clinically indicated, information and referral to community services which may include, but are not limited to: child care; elder care; housing; transportation; employment; vocational training; educational services; mental health services; financial services; and legal services.

15.3. *Training.* Where Subcontractor provides substance use disorder services and evaluates Members for access to and length of stay in substance use disorder services, Subcontractor represents and warrants that it has the training and background in substance use disorder services and working

knowledge of American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition-Revised (PPC-2R).

16. State Provisions. Subcontractor shall comply with all State and local laws, rules, regulations, executive orders and ordinances applicable to the CCO Contract or to the performance of Work under the Agreement, including but not limited to the following: (a) ORS Chapter 659A.142; (b) all other applicable requirements of State civil rights and rehabilitation statutes, rules and regulations; (c) OHA rules pertaining to the provision of prepaid capitated health care and services, OAR Chapter 410, Division 141; and (d) all other OHA Rules in OAR Chapter 410. These laws, rules, regulations, executive orders and ordinances are incorporated by reference herein to the extent that they are applicable to the CCO Contract and required by law to be so incorporated. Subcontractor shall, to the maximum extent economically feasible in the performance of the Agreement pertinent to the OHP Contact, use recycled paper (as defined in ORS 279A.010(1)(gg)), recycled PETE products (as defined in ORS 279A.010(1)(hh)), and other recycled products (as "recycled products" is defined in ORS 279A.010(1)(ii)).

17. Americans with Disabilities Act. In compliance with the Americans with Disabilities Act of 1990, any written material that is generated and provided by Subcontractor under the CCO Contract to Members, including Medicaid-Eligible Individuals, shall, at the request of such individuals, be reproduced in alternate formats of communication, to include Braille, large print, audiotape, oral presentation, and electronic format. Subcontractor shall not be reimbursed for costs incurred in complying with this provision.

18. Information/Privacy/Security/Access. If the items or services provided under the Agreement permits Subcontractor to have access to or use of any OHA computer system or other OHA Information Asset for which OHA imposes security requirements, and OHA grants Contractor access to such OHA Information Assets or Network and Information Systems, Subcontractor shall comply with OAR 943-014-0300 through OAR 943-014-0320.

19. Governing Law, Consent to Jurisdiction. The CCO Contract shall be governed by and construed in accordance with the laws of the State of Oregon without regard to principles of conflicts of law. Any claim, action, suit or proceeding between the OHA (or any other agency or department of the State of Oregon) and Subcontractor that arises from or relates to the CCO Contract shall be brought and conducted solely and exclusively within the Circuit Court of Marion County for the State of Oregon; provided, however, if a claim must be brought in a federal forum, then it shall be conducted solely and exclusively within the United States District Court of the District of Oregon. In no event shall this paragraph 19 be construed as a waiver of the State of Oregon of the jurisdiction of any court or of any form of defense to or immunity from any claim whether sovereign immunity, governmental immunity, immunity based on the Eleventh Amendment to the Constitution of the United States or otherwise. SUBCONTRACTOR, BY EXECUTION OF THE AGREEMENT, HEREBY CONSENTS TO THE IN PERSONAM JURISDICTION OF SAID COURTS.

20. Independent Contractor.

20.1. *Not an Employee of the State.* Subcontractor represents and warrants that it is not an officer, employee, or agent of the State of Oregon as those terms are used in ORS 30.265 or otherwise.

20.2. *Current Work for State or Federal Government.* If Subcontractor is currently performing work for the State of Oregon or the federal government, Subcontractor by signature to the Agreement represents and warrants that Subcontractor's Work to be performed under the Agreement creates no potential or actual conflict of interest as defined by ORS Chapter 244 and that no statutes, rules or regulations of the State of Oregon or federal agency for which Subcontractor currently performs work would prohibit

Subcontractor's work under the Agreement or the CCO Contract. If compensation under the Agreement is to be charged against federal funds, Subcontractor certifies that it is not currently employed by the federal government.

20.3. *Taxes.* Subcontractor shall be responsible for all federal and State of Oregon taxes applicable to compensation paid to Subcontractor under the Agreement, and unless Subcontractor is subject to backup withholding, OHA and Contractor will not withhold from such compensation any amount to cover Subcontractor's federal or State tax obligations. Subcontractor shall not be eligible for any social security, unemployment insurance or workers' compensation benefits from compensation paid to Subcontractor under the Agreement, except as a self-employed individual.

20.4. *Control.* Subcontractor shall perform all Work as an independent contractor. Subcontractor understands that the Contractor or CareOregon reserves the right (i) to determine and modify the delivery schedule for the Work and (ii) to evaluate the quality of the Work Product; however, Contractor or CareOregon may not and will not control the means or manner of Subcontractor's performance. Subcontractor is responsible for determining the appropriate means and manner of performing the Work delegated under the Agreement.

21. Representations and Warranties. Subcontractor represents and warrants to Contractor and CareOregon that: (a) Subcontractor has the power and authority to enter into and perform the Agreement; (b) the Agreement, when executed and delivered, shall be a valid and binding obligation of Subcontractor enforceable in accordance with its terms, (c) Subcontractor has the skill and knowledge possessed by well-informed members of its industry, trade or profession and Subcontractor will apply that skill and knowledge with care and diligence to perform the Work in a professional manner and in accordance with standards prevalent in Subcontractor's industry, trade or profession; and (d) Subcontractor shall, at all times during the term of the Agreement, be qualified, professionally competent, and duly licensed to perform the Work; and (5) Subcontractor prepared its application related to this Contract, if any, independently from all other applicants, and without collusion, fraud, or other dishonesty. The warranties set forth in this paragraph are in addition to, and not in lieu of, any other warranties provided.

22. Assignment, Successor in Interest. Subcontractor shall not assign or transfer its interest in the Agreement, voluntarily or involuntarily, whether by merger, consolidation, dissolution, operation of law, or in any other matter, without prior written consent of CareOregon. Any such assignment or transfer, if approved, is subject to such conditions and provisions as CareOregon and OHA may deem necessary. No approval by CareOregon of any assignment or transfer of interest shall be deemed to create any obligation of CareOregon in addition to those set forth in the Agreement. The provisions of the Agreement shall be binding upon and inure to the benefit of the parties, their respective successors and permitted assigns.

23. Subcontracts. Where Subcontractor is permitted to subcontract certain functions of the Agreement, Subcontractor shall notify CareOregon, in writing, of any subcontract(s) for any of the Work required by the CCO Contract other than information submitted in Exhibit G of the CCO Contract. In addition, Subcontractor shall ensure that any subcontracts are in writing and include all the requirements set forth in this Exhibit that are applicable to the service or activity delegated under the subcontract.

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

25. Limitations of Liabilities. Subcontractor agrees that OHA, Contractor and CareOregon shall not be held liable for any of Subcontractor's debts or liabilities in the event of insolvency.

26. Compliance with Federal Laws. Subcontractor shall comply with federal laws as set forth or incorporated, or both, in the CCO Contract and all other federal laws applicable to Subcontractor's performance relating to the CCO Contract or the Agreement. For purposes of the CCO Contract and the Agreement, all references to federal laws are references to federal laws as they may be amended from time to time. In addition, unless exempt under 45 CFR Part 87 for Faith-Based Organizations, or other federal provisions, Subcontractor shall comply with the following federal requirements to the extent that they are applicable to the CCO Contract and the Agreement:

26.1. *Federal Provisions.* Subcontractor shall comply with all federal laws, regulations, and executive orders applicable to the CCO Contract or to the delivery of Work under the Agreement. Without limiting the generality of the foregoing, Subcontractor expressly agrees to comply with the following laws, regulations and executive orders to the extent they are applicable to the CCO Contract and the Agreement: (a) Title VI and VII of the Civil Rights Act of 1964, as amended, (b) 45 CFR Part 84 which implements Title V, Sections 503 and 504 of the Rehabilitation Act of 1973, as amended, (c) the Americans with Disabilities Act of 1990, as amended, (d) Executive Order 11246, as amended, (e) the Health Insurance Portability and Accountability Act of 1996, as amended, (f) the Age Discrimination in Employment Act of 1967, as amended, and the Age Discrimination Act of 1975, as amended, (g) the Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended, (h) all regulations and administrative rules established pursuant to the foregoing laws, (i) all other applicable requirements of federal civil rights and rehabilitation statutes, rules and regulations, and (j) all federal law governing operation of community mental health programs, including without limitation, all federal laws requiring reporting of Client abuse. These laws, regulations and executive orders are incorporated by reference herein to the extent that they are applicable to the CCO Contract and the Agreement and required by law to be so incorporated. No federal funds may be used to provide Work in violation of 42 USC 14402.

26.2. *Equal Employment Opportunity.* If the CCO Contract, including amendments, is for more than \$10,000, then Subcontractor 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).

26.3. *Clean Air, Clean Water, EPA Regulations.* If the CCO Contract, including amendments, exceeds \$100,000 then Subcontractor shall comply with all applicable standards, orders, or requirements issued under Section 306 of the Clean Air Act (42 USC 7606), the Federal Water Pollution Control Act as amended (commonly known as the Clean Water Act) (33 USC 1251 to 1387), specifically including, but not limited to Section 508 (33 USC 1368), Executive Order 11738, and Environmental Protection Agency regulations (2 CFR Part 1532), which prohibit the use under non exempt federal contracts, grants or loans of facilities included on the EPA List of Violating Facilities. Violations shall be reported to OHA, the U.S. Department of Health and Human Services and the appropriate Regional Office of the Environmental Protection Agency. Subcontractor shall include in all contracts with subcontractors receiving more than \$100,000, language requiring the subcontractor to comply with the federal laws identified in this subparagraph.

26.4. *Energy Efficiency.* Subcontractor shall comply with applicable mandatory standards and policies relating to energy efficiency that are contained in the Oregon energy conservation plan issued in compliance with the Energy Policy and Conservation Act, 42 USC 6201 et seq. (Pub. L. 94-163).

26.5. *Truth in Lobbying.* Subcontractor certifies, to the best of the Subcontractor's knowledge and belief that:

a. No federal appropriated funds have been paid or will be paid, by or on behalf of Subcontractor, to any person for influencing or attempting to influence an officer or employee of an agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment or modification of any federal contract, grant, loan or cooperative agreement.

b. If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with this federal contract, grant, loan or cooperative agreement, the Subcontractor shall complete and submit Standard Form LLL, "Disclosure Form to Report Lobbying" in accordance with its instructions.

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

d. This certification is a material representation of fact upon which reliance was placed when this Contract was made or entered into. Submission of this certification is a prerequisite for making or entering into this Contract imposed by Section 1352, Title 31, of the U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

e. No part of any federal funds paid to Subcontractor under this Contract shall be used other than for normal and recognized executive legislative relationships, for publicity or propaganda purposes, for the preparation, distribution, or use of any kit, pamphlet, booklet, publication, electronic communication, radio, television, or video presentation designed to support or defeat the enactment of legislation before the United States Congress or any State or local legislature itself, or designed to support or defeat any proposed or pending regulation, administrative action, or order issued by the executive branch of any State or local government itself.

f. No part of any federal funds paid to Subcontractor under this Contract shall be used to pay the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or executive order proposed or pending before the United States Congress or any State government, State legislature or local legislature or legislative body, other than for normal and recognized executive-legislative relationships or participation by an agency or officer of a State, local or tribal government in policymaking and administrative processes within the executive branch of that government.

g. The prohibitions in subsections (e) and (f) of this section shall include any activity to advocate or promote any proposed, pending or future Federal, State or local tax increase, or any proposed, pending, or future requirement or restriction on any legal consumer product, including its sale or marketing, including but not limited to the advocacy or promotion of gun control.

h. No part of any federal funds paid to Subcontractor under this Contract may be used for any activity that promotes the legalization of any drug or other substance included in schedule I of the schedules of controlled substances established under Section 202 of the Controlled Substances Act except for normal and recognized executive congressional communications. This limitation shall not apply when there is significant medical evidence of a therapeutic advantage to the use of such drug or

other substance of that federally sponsored clinical trials are being conducted to determine therapeutic advantage.

26.6. *HIPAA Compliance.* Subcontractor acknowledges and agrees that Contractor is a “covered entity” for purpose of the privacy and security provisions of HIPAA. Accordingly, Subcontractor shall comply with HIPAA and the following:

a. Individually Identifiable Health Information (“IIHI”) about specific individuals is protected from unauthorized use or disclosure consistent with the requirement of HIPAA. IIHI relating to specific individuals may be exchanged between Subcontractor and Contractor and between Subcontractor and OHA for purposes directly related to the provision of services to Members which are funded in whole or in part under the CCO Contract. However, Subcontractor shall not use or disclose any IIHI about specific individuals in a manner that would violate (i) the HIPAA Privacy Rules in 45 CFR Parts 160 and 164; (ii) the OHA Privacy Rules, OAR Chapter 407 Division 014 ., or (iii) the OHA Notice of Privacy Practices, if done by OHA. A copy of the most recent OHA Notice of Privacy Practices is posted on the OHA web site at: <https://apps.state.or.us/cfi/FORMS/>, Form number ME2090, or may be obtained from OHA.

b. Subcontractor shall adopt and employ reasonable administrative and physical safeguards consistent with the Security Rule in 45 CFR Part 164 to ensure that Member Information is used by or disclosed only to the extent necessary for the permitted use or disclosure and consistent with applicable State and federal laws and the terms and conditions of the CCO Contract and the Agreement. Security incidents involving Member Information must be immediately reported to the Contractor’s privacy officer and to the Oregon Department of Human Services’ (“DHS”) Privacy Officer.

c. Subcontractor shall comply with the HIPAA standards for electronic transactions published in 45 CFR Part 162 and the DHS Electronic Data Transmission Rules, OAR 410-001-0000 through 410-001-0200. If Contractor intends to exchange electronic data transactions with OHA in connection with Claims or encounter data, eligibility or enrollment information, authorizations or other electronic transactions, Subcontractor shall comply with OHA Electronic Data Transmission Rules.

d. If Subcontractor reasonably believes that the Contractor’s or OHA’s data transactions system or other application of HIPAA privacy or security compliance policy may result in a violation of HIPAA requirements, Subcontractor shall promptly consult Contractor or the OHA HIPAA officer.

26.7. *Resource Conservation and Recovery.* 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 6901 et. seq.). Section 6002 of that Act (codified at 42 USC 6962) requires that preference be given in procurement programs to the purchase of specific products containing recycled materials identified in guidelines developed by the Environmental Protection Agency.

26.8. *Audits.* Subcontractor shall comply with the applicable audit requirements and responsibilities set forth in the Office of Management and Budget Circular A-133 entitled “Audits of States, Local Governments and Non-Profit Organizations.”

26.9. *Debarment and Suspension.* Subcontractor represents and warrants that:

a. Subcontractor is not excluded by the U.S. Department of Health and Human Services Office of the Inspector General or listed on the non-procurement portion of the General Service Administration’s “List of Parties Excluded from Federal Procurement or Nonprocurement

Programs” in accordance with Executive Orders No. 12549 and No. 12689, “Debarment and Suspension.”

b. Subcontractor is not excluded from participation in Medicare or Medicaid for any of the following reasons:

i. Subcontractor is controlled by a sanctioned individual.

ii. Subcontractor has a contractual relationship that provides for the administration, management or provision of medical services, or the establishment of policies, or the provision of operational support for the administration, management or provision of medical services, either directly or indirectly, with an individual convicted of certain crimes as described in section 1128(b)(8)(B) of the Social Security Act.

iii. Subcontractor employs or contracts, directly or indirectly, for the furnishing of health care, utilization review, medical social work, or administrative services, with one of the following:

Any individual or entity excluded from participation in Federal health care programs.

Any entity that would provide those services through an excluded individual or entity.

The Subcontractor is prohibited from knowingly having a person with ownership of more than 5% of the Contractor’s equity who is (or is affiliated with a person/entity that is) debarred, suspended, or excluded from participation in federal healthcare programs.

26.10. *Drug-Free Workplace.* Subcontractor shall comply with the following provisions to maintain a drug-free workplace:

a. Subcontractor certifies that it will provide a drug-free workplace by publishing a statement notifying its employees that the unlawful manufacture, distribution, dispensation, possession or use of a controlled substance, except as may be present in lawfully prescribed or over-the-counter medications, is prohibited in Subcontractor’s workplace or while providing services to Members. Subcontractor’s notice shall specify the actions that will be taken by Subcontractor against its employees for violation of such prohibitions;

b. Establish a drug-free awareness program to inform its employees about: the dangers of drug abuse in the workplace, Subcontractor’s policy of maintaining a drug-free workplace, any available drug counseling, rehabilitation, and employee assistance programs, and the penalties that may be imposed upon employees for drug abuse violations;

c. Provide each employee to be engaged in the performance of services under the Agreement a copy of the statement mentioned in subparagraph 26.10.a above;

d. Notify each employee in the statement required by subparagraph 26.10.a that, as a condition of employment to provide services under the CCO Contract the employee will: abide by the terms of the statement, and notify the employer of any criminal drug statute conviction for a violation occurring in the workplace no later than five days after such conviction;

e. Notify OHA, CareOregon and Contractor within ten days after receiving notice under subparagraph 26.10.d from an employee or otherwise receiving actual notice of such conviction;

f. Impose a sanction on, or require the satisfactory participation in a drug abuse assistance or rehabilitation program by, any employee who is so convicted as required by Section 5154 of the Drug-Free Workplace Act of 1988;

g. Make a good-faith effort to continue a drug-free workplace through implementation of subparagraphs 26.10.a through 26.10.f;

h. Require any subcontractor to comply with subparagraphs 26.10.a through 26.10.g;

i. Neither Subcontractor, nor any of Subcontractor's employees, officers, agents or subcontractors may provide any service required under the Agreement while under the influence of drugs. For purposes of this provision, "under the influence" means: observed abnormal behavior or impairments in mental or physical performance leading a reasonable person to believe the Subcontractor or Subcontractor's employee, officer, agent or subcontractor has used a controlled substance, prescription or non-prescription medication that impairs the Subcontractor or Subcontractor's employee, officer, agent or subcontractor's performance of essential job function or creates a direct threat to Members or others. Examples of abnormal behavior include, but are not limited to: hallucinations, paranoia or violent outbursts. Examples of impairments in physical or mental performance include, but are not limited to: slurred speech, difficulty walking or performing job activities;

j. Violation of any provision of this subparagraph 26.10 may result in termination of the Agreement and the CCO Contract.

26.11. *Pro-Children Act.* Subcontractor shall comply with the Pro-Children Act of 1994 (codified at 20 USC Section 6081 et. seq.).

26.12. *Clinical Laboratory Improvements.* Subcontractor and any laboratories used by Subcontractor shall comply with the Clinical Laboratory Improvement Amendments (CLIA 1988), 42 CFR Part 493 Laboratory Requirements and ORS 438, which require that all laboratory testing sites providing services under the CCO Contract shall have either a Clinical Laboratory Improvement Amendments ("CLIA") certificate of waiver or a certificate of registration along with a CLIA identification number. Laboratories with certificates of waiver will provide only the eight types of tests permitted under the terms of the waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.

26.13. *OASIS.* To the extent applicable, Subcontractor shall comply with the Outcome and Assessment Information Set ("OASIS") reporting requirements and patient notice requirements for skilled services provided by Home Health Agencies, pursuant to the CMS requirements published in 42 CFR 484.20, and such subsequent regulations as CMS may issue in relation to the OASIS program.

26.14. *Patient Rights Condition of Participation.* To the extent applicable, Subcontractor shall comply with the Patient Rights Condition of Participation that hospitals must meet to continue participation in the Medicaid program, pursuant to 42 CFR Part 482. For purposes of this Exhibit, hospitals include short-term, psychiatric, rehabilitation, long-term, and children's hospitals.

26.15. *Federal Grant Requirements.* Subcontractor shall not expend any of the funds paid under the Agreement for roads, bridges, stadiums, or any other item or service not covered under the Oregon Health Plan ("OHP").

27. Marketing. Subcontractor shall not initiate contact nor Market independently to potential Clients, directly or through any agent or independent contractor, in an attempt to influence an OHP Client's Enrollment with Contractor, without the express written consent of OHA. Subcontractor shall not conduct, directly, door-to-door, telephonic, mail, electronic, or other Cold Call Marketing practices to entice a Client to enroll with Contractor, or to not enroll with another CCO Contractor. Subcontractor shall not seek to influence a Client's Enrollment with the Contractor in conjunction with the sale of any other insurance. Furthermore, Subcontractor understands that OHA must approve, prior to distribution, any written communication by Subcontractor that (a) is intended solely for Members, and (b) pertains to provider requirements for obtaining coordinated care services, care at service site or benefits.

28. Workers' Compensation Coverage. If Subcontractor employs subject workers, as defined in ORS 656.027, then Subcontractor shall comply with ORS 656.017 and shall provide workers' compensation insurance coverage for those workers, unless they meet the requirements for an exemption under ORS 656.126(2).

29. Third Party Resources.

29.1. *Provision of Covered Services*. Subcontractor may not refuse to provide Covered Services to a Member because of a Third Party Resource's potential liability for payment for the Covered Services.

29.2. *Reimbursement*. Subcontractor understands that where Medicare and Contractor have paid for services, and the amount available from the Third Party Liability is not sufficient to satisfy the Claims of both programs to reimbursement, the Third Party Liability must reimburse Medicare the full amount of its Claim before any other entity, including Subcontractor, may be paid. In addition, if a Third Party has reimbursed Subcontractor, or if a Member, after receiving payment from a Third Party Liability, has reimbursed Subcontractor, the Subcontractor shall reimburse Medicare up to the full amount the Subcontractor received, if Medicare is unable to recover its payment from the remainder of the Third Party Liability payment.

29.3. *Confidentiality*. When engaging in Third Party Resource recovery actions, Subcontractor shall comply with federal and State confidentiality requirements, described in Exhibit B of the CCO Contract.

29.4. *No Compensation*. Except as permitted by the CCO Contract including Third Party Resources recovery, Subcontractor may not be compensated for Work performed under the CCO Contract from any other department of the State, nor from any other source including the federal government.

29.5. *Third Party Liability*. Subcontractor shall maintain records of Subcontractor's actions related to Third Party Liability recovery, and make those records available for Contractor and OHA review.

29.6. *Right of Recovery*. Subcontractor shall comply with 42 USC 1395y(b), which gives Medicare the right to recover its benefits from employers and workers' compensation carriers, liability insurers, automobile or no fault insurers, and employer group health plans before any other entity including Contractor or Subcontractor.

29.7. *Disenrolled Members*. If OHA retroactively disenrolls a Member at the time the Member acquired Third Party Liability insurance, pursuant to OAR 410-141-3080(2)(b)(D) or 410-141-3080(3)(a)(A), Subcontractor may not seek to collect from a Member (or any financially responsible Representative) or any Third Party Liability, any amounts paid for any Covered Services provided on or after the date of Disenrollment.

30. Preventive Care. Where Subcontractor provides Preventive Care Services, all Preventive Care Services provided by Subcontractor to Members shall be reported to Contractor and shall be subject to Contractor's Medical Case Management and Record Keeping responsibilities.

31. Accessibility.

31.1. *Timely Access, Hours.* Subcontractor shall meet OHP standards for timely access to care and services, taking into account the urgency of the need for services as specified in OAR 410-141-3220. This requirement includes that Subcontractor offer hours of operation that are not less than the hours of operation offered to Contractor's commercial members (as applicable) and non-Members as provided in OAR 410-141-3220.

31.2. *Special Needs.* Subcontractor and Subcontractor's facilities shall meet the special needs of Members who require accommodations because of a disability or limited English proficiency.

32. Member Rights.

32.1. *Treating Members with Respect and Equality.* If Subcontractor is a Participating Provider, Subcontractor shall treat each Member with respect and with due consideration for his or her dignity and privacy. In addition, Subcontractor shall treat each Member the same as other patients who receive services equivalent to Covered Services.

32.2. *Information on Treatment Options.* If Subcontractor is a Participating Provider, Subcontractor shall ensure that each Member receives information on available treatment options and alternatives in a manner appropriate to the Member's condition and ability to understand.

32.3. *Participation Decisions.* If Subcontractor is a Participating Provider, Subcontractor shall allow each Member to participate in decisions regarding his or her healthcare, including the right to refuse treatment, and decisions regarding coordination of follow up care. [Exhibit B, Part 3, Paragraph 2]

32.4. *Copy of Medical Records.* Subcontractor shall ensure that each Member is allowed to request and receive a copy of his or her medical records and request that they be amended or corrected as specified in 45 CFR 164.524 and 164.526.

32.5. *Exercise of Rights.* Subcontractor shall ensure that each Member is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the Subcontractor, its staff, its subcontractors, its Participating Providers, or OHA treat the Member.

33. Grievance System. Subcontractor shall cooperate with DHS's Governor's Advocacy Office, the OHA Ombudsman and hearing representatives in all of the OHA's activities related to Members' grievances, appeals and hearings including providing all requested written materials.

34. Authorization of Service. Subcontractor shall follow Contractor's procedures for the initial and continuing authorizations for services as defined in OAR 410-141-0000, which requires that any decision to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested, be made by a Health Care Professional who has appropriate clinical expertise in treating the Member's health or mental health condition or disease in accordance with 42 CFR 438.210. In addition, Subcontractor must obtain authorization for Covered Services from Contractor, except to the extent prior authorization is not required in OAR 410-141-2420 or elsewhere in the CCO Contract Statement of Work.

35. Non-Discrimination. Subcontractor shall not discriminate between Members and non-OHP persons as it relates to benefits and services to which they are both entitled.

36. Record Keeping System. If Subcontractor is a Participating Provider, Subcontractor shall, based on written policies and procedures, develop and maintain a record keeping system that: (a) includes sufficient detail and clarity to permit internal and external review to validate encounter submissions and to assure Medically Appropriate services are provided consistent with the documented needs of the Member; (b) conforms to accepted professional practice; and (c) allows the Subcontractor to ensure that data submitted to Contractor is accurate and complete by: (i) verifying the accuracy and timeliness of reported data; (ii) screening the data for completeness, logic, and consistency; and (iii) collecting service information in standardized formats to the extent feasible and appropriate.

37. Enrollment; Unique Provider Identification Number. Each of Subcontractor's Physicians and other qualified providers, if any, shall be enrolled with OHA and have a unique provider identification number that complies with 42 USC 1320d-2(b).

38. Accreditation. If Subcontractor is a Participating Provider and provides programs or facilities that are not required to be licensed or certified by a State of Oregon board or licensing agency, then such programs or facilities operated by Subcontractor shall be accredited by nationally recognized organizations recognized by OHA for the services provided or The Joint Commission where such accreditation is required by OHA rule to provide the specific service or program.

39. Advocacy. Except as provided in the CCO Contract, Contractor shall not prohibit or otherwise limit or restrict Subcontractor's Health Care Professionals acting within the lawful scope of practice, from advising or advocating on behalf of a Member, who is a patient of the professional, for the following : (a) for the Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered, that is Medically Appropriate even if such care or treatment is not covered under the CCO Contract or is subject to Co-Payment; (b) any information the Member needs in order to decide among relevant treatment options; (c) the risks, benefits, and consequences of treatment or non-treatment; and (d) the Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

40. Health Information Technology. Subcontractor shall comply with Contractor's policies and procedures relating to electronic health information exchange to support the exchange of patient health information among Participating Providers.

41. No Actions. To the extent Subcontractor is a Participating Provider, Subcontractor represents and warrants that neither the state nor federal government has brought any past or pending investigations, legal actions, administrative actions, or matters subject to arbitration involving the Subcontractor, including key management or executive staff, over the past three years on matters relating to payments from governmental entities, both federal and state, for healthcare or prescription drug services.

42. Notice of Termination. Subcontractor acknowledges and agrees that Contractor will provide written notice of the termination of Subcontractor's agreement with Contractor to provide Covered Services to Members, within 15 days of such termination, to each Member who received his or her primary care from, or was seen on a regular basis by, the Subcontractor.

43. Subrogation. Subcontractor agrees to subrogate to OHA any and all claims the Contractor or Subcontractor has or may have against manufacturers, wholesale or retail suppliers, sales representatives, testing laboratories, or other providers in the design, manufacture, marketing, pricing or

quality of drugs, pharmaceuticals, medical supplies, medical devices, durable medical equipment or other products.

44. Stop-Loss Documentation. If Subcontractor participates in a Practitioner Incentive Plan under the Agreement that places Subcontractor at Substantial Financial Risk, Subcontractor shall submit stop-loss documentation to Contractor in accordance with Contractor's policies and procedures.

**EXHIBIT C
PROGRAM ATTACHMENT**

MEDICARE ADVANTAGE REQUIREMENTS

The Department of Health and Human Services, Centers for Medicare and Medicaid Services (“CMS”) requires that specific terms and conditions be incorporated into the agreement between a Medicare Advantage Organization or First Tier Entity and a First Tier Entity or Downstream Entity to comply with the Medicare laws, regulations, and CMS instructions, including, but not limited to, the Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub. L. No. 108173, 117 Stat. 2066 (“MMA”); and

Except as provided herein, all other provisions of the Provider Agreement (“Agreement”) not inconsistent herein shall remain in full force and effect. This Exhibit shall supersede and replace any inconsistent provisions to such Agreement; to ensure compliance with required CMS provisions, and shall continue concurrently with the term of such Agreement.

Definitions:

The following definitions shall be applicable to this Exhibit.

Centers for Medicare and Medicaid Services (“CMS”) means the agency within the Department of Health and Human Services that administers the Medicare program.

Completion of Audit means completion of audit by the Department of Health and Human Services, the Government Accountability Office, or their designees of a Medicare Advantage Organization, Medicare Advantage Organization contractor or related entity.

Downstream Entity means any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the Medicare Advantage (“MA”) benefit, below the level of the arrangement between an MA organization (or applicant) and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

Final Contract Period means the final term of the contract between CMS and the Medicare Advantage Organization.

First Tier Entity means any party that enters into a written arrangement, acceptable to CMS, with an MA organization or applicant to provide administrative services or health care services for a Medicare eligible individual under the MA program.

Medicare Advantage (“MA”) means an alternative to the traditional Medicare program in which private plans run by health insurance companies provide health care benefits that eligible beneficiaries would otherwise receive directly from the Medicare program.

Medicare Advantage Organization ("MA Organization") means a public or private entity organized and licensed by a State as a risk-bearing entity (with the exception of provider-sponsored organizations receiving waivers) that is certified by CMS as meeting the MA contract requirements.

Member means a Medicare Advantage eligible individual who has enrolled in or elected coverage through a Medicare Advantage Organization.

Provider means (1) any individual who is engaged in the delivery of health care services in a State and is licensed or certified by the State to engage in that activity in the State; and (2) any entity that is engaged in the delivery of health care services in a State and is licensed or certified to deliver those services if such licensing or certification is required by State law or regulation.

Related Entity means any entity that is related to the MA Organization by common ownership or control and (1) performs some of the MA Organization's management functions under contract or delegation; (2) furnishes services to Medicare Members under an oral or written agreement; or (3) leases real property or sells materials to the MA Organization at a cost of more than \$2,500 during a contract period.

Contracted Provider is a First Tier Entity. Contracted Provider agrees and shall ensure that its Downstream Entities agree to the following:

HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any pertinent information for any particular contract period, including, but not limited to, any books, contracts, computer or other electronic systems (including medical records and documentation of Contracted Provider and its Downstream Entities and entities related to CMS' contract with any MA Organization to which Contracted Provider provides services pursuant to the Agreement through 10 years from the final date of the final contract period of the contract entered into between CMS and the MA Organization or from the date of completion of any audit, whichever is later. [42 C.F.R. §§ 422.504(i)(2)(i) and (ii)]

1. Contracted Provider and its Downstream Entities will comply with the confidentiality and Member record accuracy requirements, including: (1) abiding by all Federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information, (2) ensuring that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas, (3) maintaining the records and information in an accurate and timely manner, and (4) ensuring timely access by Members to the records and information that pertain to them. [42 C.F.R. §§ 422.504(a)(13) and 422.118]
2. Members will not be held liable for payment of any fees that are the legal obligation of the MA Organization. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)]
3. For all Members eligible for both Medicare and Medicaid, Members will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts. Contracted Provider and its Downstream Entities shall ensure all Providers providing services under the Agreement will be informed of Medicare and Medicaid benefits and rules for Members eligible for Medicare and Medicaid. Neither Contracted Provider nor Downstream Entity may

impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the Member under title XIX if the Member were not enrolled in such a plan. Providers providing services under the Agreement will: (1) accept the MA plan payment as payment in full, or (2) bill the appropriate State source. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)]

4. Any services or other activity performed by Contracted Provider in accordance with the Agreement, or by Contracted Provider's Downstream Entity pursuant to an agreement between Contracted Provider and its Downstream Entity, are consistent and comply with the MA Organization's contractual obligations. [42 C.F.R. § 422.504(i)(3)(iii)]
5. Pursuant to 42 C.F.R. §§ 422.520(b)(1) and (2), the Agreement has a prompt payment provision. See Paragraph 5.02 of the Agreement.
6. Contracted Provider and any related entity, contractor or subcontractor will comply with all applicable Medicare laws, regulations, and CMS instructions. [42 C.F.R. §§ 422.504(i)(4)(v)]. To the extent required by law Contracted Provider shall monitor the compliance of Contracted Provider's Downstream Entities will comply with all applicable Medicare laws, regulations, and CMS instructions.
7. The MA Organization's activities or responsibilities under its contract with CMS are delegated to Contracted Provider as follows:
 - (i) See paragraph 4.02 regarding Contracted Provider's obligations and duties.
 - (ii) See Paragraph 7.02 regarding CareOregon's right to terminate the Agreement The MA Organization will monitor the performance of the parties on an ongoing basis pursuant to Paragraphs 4.10(i) and 6.02 of the Agreement.
 - (iii) The credentials of Providers providing services pursuant to the Agreement shall be either reviewed by the MA Organization or the credentialing process will be reviewed and approved by the MA Organization and the MA Organization shall audit the credentialing process on an ongoing basis. See Agreement paragraph 4.01 (c).
 - (iv) If the MA Organization delegates the selection of providers, contractors, or subcontractor, the MA Organization retains the right to approve, suspend, or terminate any such arrangement. See Agreement paragraph 7.02(b)(ii) and (c) (ability to terminate with respect to any Provider).

[42 C.F.R. §§ 422.504(i)(4) and (5)]

In the event of a conflict between the terms and conditions above and the terms of a related agreement, the terms above control.

EXHIBIT D

PROFESSIONAL SERVICES

SCHEDULE OF PAYMENT FOR OHP/MEDICAID PLANS:

This schedule establishes Payment for professional services rendered to OHP/Medicaid Recipients under this Agreement. CareOregon will use the formulas and other methodologies set forth in this Exhibit and the Fee Schedule Specifications, as amended from time to time as stated herein. Except as stated below with respect to Non-Material Changes, CareOregon may make changes to this Exhibit and the Fee Schedule Specifications as stated in Section 11.1 of the Agreement. CareOregon may make Non-Material Changes to the Fee Schedule Specifications immediately upon notice to Provider. "Non-material Changes" shall mean routine updates to CPT or other nationally recognized codes (for example, codes are replaced, retired, or split into two codes).

CareOregon Fee Schedule			
Conversion Factor	\$35.8228		
Fee Schedule Structure:			
CareOregon will pay the covered services using relative value units based on the 2014 Resource-based Relative Value Scale (RBRVS) CMS RVU File RVU14D released on 08/19/2014. The Geographic Practice Cost Index (GPCI) will not be used.			
Special Carve-out Segments:			
<u>Maternity w/\$300 Add On:</u>			
Conversion factor plus \$300			
59400	59510	59610	59618
59409	59514	59612	59620
59410	59515	59614	59622

A complete list of specific codes shall be made available upon written request.

ANESTHESIA

CareOregon will use a \$24.30 conversion factor applied to the base units (and time units) published annually in the American Society of Anesthesiologists (ASA) Relative Value Guide to established its fee schedule.

EXHIBIT D (Cont)

PROFESSIONAL SERVICES

SCHEDULE OF PAYMENT FOR OHP/MEDICAID PLANS:

DEFAULT REIMBURSEMENT FOR OHP PLANS

For Covered Services that have no established value on the RBRVS Fee Schedule CareOregon will apply applicable published DMAP/OHP Fee Schedule rates in effect on the date of service. For Covered Services that have no DMAP/OHP Fee Schedule value, CareOregon will apply the CareOregon default rate in effect at the date of service.

CONFIDENTIALITY

This Exhibit and the Fee Schedule Specifications contain confidential and proprietary information and they are considered a trade secret of CareOregon. To the extent authorized by Oregon law, neither party will disclose this or any other proprietary information or trade secret without the express written approval of the other party.

OTHER

Any copays, coinsurance, deductibles or any other cost sharing, if any, shall be offset against the allowed amount for Covered Services, without regard to whether Provider has collected such amounts. Provider's Payment may be reduced by the amount of any applicable cost sharing, depending on the form of Member's benefit plan.

EXHIBIT D-1

**PROFESSIONAL SERVICES
ENHANCED FEE SCHEDULE**

SCHEDULE OF PAYMENT FOR OHP/MEDICAID PLANS:

All codes that are eligible to be billed with a "GT" modifier designating a Telehealth service will be reimbursed at 125% of the Contracted Rate. All codes billed with the GT modifier must follow current State and Federal coding guidelines.

CareOregon Enhanced Fee Schedule

CPT	CPT Description	Contracted Rate
96150	Hlth&behavior Assmt Ea 15 Min W/Pt 1st Assmt	\$ 65.00
96151	Hlth&behavior Assmt Ea 15 Min W/Pt Re-Assmt	\$ 60.00
96152	Hlth&behavior Ivntj Ea 15 Min Indiv	\$ 60.00
96153	Hlth&behavior Ivntj Ea 15 Min Grp 2/>pts	\$ 45.00
96154	Hlth&behavior Ivntj Ea 15 Min Fam W/Pt	\$ 60.00
97802	Medical Nutrition Assmt&ivntj Indiv Each 15 Mi	\$ 60.00
97803	Medical Nutrition Re-Assmt&ivntj Indiv Ea 15 M	\$ 55.00
97804	Medical Nutrition Therapy Grp2/ Indiv Ea 30 Mi	\$ 45.00
99201	Office Outpatient New 10 Minutes	\$ 65.00
99211	Office Outpatient Visit 5 Minutes	\$ 55.00
99212	Office Outpatient Visit 10 Minutes	\$ 65.00
99406	Tobacco Use Cessation Intermediate 3-10 Minutes	\$ 45.00
99407	Tobacco Use Cessation Intensive >10 Minutes	\$ 55.00
G0396	Alcohol &/Substance Abuse Assessment 15-30 Min	\$ 65.00
G0397	Alcohol &/Substance Abuse Assessment >30 Min	\$ 95.00
99408	Alcohol &/Substance Abuse Assessment 15-30 Min	\$ 45.00
99409	Alcohol &/Substance Abuse Assessment >30 Min	\$ 55.00
G0436	Smoke Tob Cessation Cnsl As Pt; Intrmed 3-10 Min	\$ 45.00
G0437	Smoking & Tob Cess Cnsl As Pt; Intermed >10 Min	\$ 55.00
G0442	Annual Alcohol Misuse Screening 15 Minutes	\$ 50.00
G0443	Brief Face-Face Behav Cnsl Alcohl Misuse 15 Min	\$ 55.00
G0444	Annual Depression Screening 15 Minutes	\$ 50.00
G0445	Sa Hi Intens Cnsl Prev Sti Ind F/F Edu Chng Bhvr	\$ 65.00
G0446	Annual Fce--Fce Intensv Behv Tx Cv Dz Ind 15 Min	\$ 65.00
G0447	Face--Face Behavioral Counseling Obesity 15 Min	\$ 65.00
G0108	Diab Op Self-Mgmt Trn Srv Individual Per 30 Min	\$ 70.00
G0109	Diab Self-Mgmt Trn Srv Group Session Per 30 Min	\$ 50.00
98966	Telephone assessment and mgmt qualified non-physician 5-10 min	\$ 55.00
98967	Telephone assessment and mgmt qualified non-physician 11-20 min	\$ 65.00
98968	Telephone assessment and mgmt qualified non-physician 21-30 min	\$ 70.00
98969	On-line assessment and mgmt qualified non-physician	\$ 65.00

EXHIBIT D-1 (Cont)

**PROFESSIONAL SERVICES
ENHANCED FEE SCHEDULE**

SCHEDULE OF PAYMENT FOR OHP/MEDICAID PLANS:

CareOregon Enhanced Fee Schedule

CPT	CPT Description	Contracted Rate
99441	Telephone assessment and mgmt. qualified healthcare professional 5-10 min	\$ 75.00
99442	Telephone assessment and mgmt. qualified healthcare professional 11-20 min	\$ 85.00
99443	Telephone assessment and mgmt. qualified healthcare professional 21-30 min	\$ 91.00
99444	On-line assessment and mgmt qualified healthcare professional	\$ 91.00
GT	Telehealth Modifier	125%

DEFAULT REIMBURSEMENT OHP PLANS

For Covered Services that have no established value on the RBRVS Fee Schedule CareOregon will apply applicable published DMAP/OHP Fee Schedule rates in effect on the date of service. For Covered Services that have no DMAP/OHP Fee Schedule value, CareOregon will apply the CareOregon default rate in effect at the date of service.

CONFIDENTIALITY

This Exhibit and the Fee Schedule Specifications contain confidential and proprietary information and they are considered a trade secret of CareOregon. To the extent authorized by Oregon law, neither party will disclose this or any other proprietary information or trade secret without the express written approval of the other party.

OTHER

Any copays, coinsurance, deductibles or any other cost sharing, if any, shall be offset against the allowed amount for Covered Services, without regard to whether Provider has collected such amounts. Provider's Payment may be reduced by the amount of any applicable cost sharing, depending on the form of Member's benefit plan.

EXHIBIT D-2

PROFESSIONAL SERVICES

SCHEDULE OF PAYMENT FOR MEDICARE ADVANTAGE PLANS:

This schedule establishes Payment for professional services rendered to Medicare Beneficiaries under this Agreement. CareOregon will use the formulas and other methodologies set forth in this Exhibit, as amended from time to time as stated herein. Except as stated below with respect to Non-material Changes, CareOregon may make changes to this Exhibit and the Fee Schedule Specifications as stated in Section 8.14 of the Agreement. CareOregon may make Non-Material Changes to the Fee Schedule Specifications immediately upon notice to Provider. "Non-material Changes" shall mean routine updates to CPT or other nationally recognized codes (for example, codes are replaced, retired, or split into two codes).

CareOregon Fee Schedule

CareOregon will pay 100 % of the current Medicare payment policies and fee schedule applicable to Provider as published annually in the Federal Register and based on valid codes recognized by CMS in effect on the date of service. For Covered Services that have no Medicare schedule value, CareOregon will pay Provider according to CareOregon Policies.

CONFIDENTIALITY

This Exhibit and the Fee Schedule Specifications contain confidential and proprietary information and they are considered a trade secret of CareOregon. To the extent authorized by Oregon law, neither party will disclose this or any other proprietary information or trade secret without the express written approval of the other party.

OTHER

Any copays, coinsurance, deductibles or any other cost sharing, if any, shall be offset against the allowed amount for Covered Services, without regard to whether Provider has collected such amounts. Provider's Payment may be reduced by the amount of any applicable cost sharing, depending on the form of Member's benefit plan.

EXHIBIT E

CHEMICAL DEPENDENCY SERVICES

SCHEDULE OF PAYMENT FOR OHP/MEDICAID:

This schedule establishes Payment for services rendered to OHP/Medicaid Recipients under this Agreement. Per this Agreement, provider shall submit fee for service claims within one hundred twenty (120) days of the provision of the service being billed. CareOregon shall reimburse Provider for covered services at the current rates published by the Division of Medical Assistance Program (DMAP) and update as notified by DMAP. Fee for service payments are based on the rate schedule in effect on the dates of service. Currently the rates are as follow and are subject to change with DMAP updates. CareOregon may make Non-Material Changes to the Fee Schedule Specifications immediately upon notice to Provider. "Non-material Changes" shall mean routine updates to HCPCS/CPT or other nationally recognized codes (for example, codes are replaced, retired, or split into two codes).

CareOregon Chemical Dependency Fee Schedule

CareOregon will pay the covered services using current rates published by the Division of Medical Assistance Program (DMAP) based on the rate schedule in effect on the dates of service.

Medicaid Procedure Codes and Reimbursement Rates billing requirements and pricing
<http://www.oregon.gov/oha/healthplan/Pages/policies.aspx>

- When billing for Chemical Dependency treatment, the POS must be 03, 11, 12, 53, 57 or 99 with modifier HF when required
- When billing for Methadone treatment, the POS must be 49 with modifier HG when required
- Current DHS payment based on date of service

DISCRETIONARY COMPENSATION

CareOregon within its sole discretion may, from time-to-time, establish a program or programs to encourage the improvement of the delivery of health care to its Members, including but not limited to the Care Support and System Innovation (CSSI) Program. Any such program(s) together with the criteria for participation by Providers in the program(s) will be governed and administered by written policies and program descriptions developed by CareOregon.

CONFIDENTIALITY

This Exhibit and the Fee Schedule Specifications contain confidential and proprietary information and they are considered a trade secret of CareOregon. To the extent authorized by Oregon law, neither party will disclose this or any other proprietary information or trade secret without the express written approval of the other party.

EXHIBIT E (Cont)

CHEMICAL DEPENDENCY SERVICES

SCHEDULE OF PAYMENT FOR OHP/MEDICAID:

OTHER

Any copays, coinsurance, deductibles or any other cost sharing, if any, shall be offset against the allowed amount for Covered Services, without regard to whether Provider has collected such amounts. Provider's Payment may be reduced by the amount of any applicable cost sharing, depending on the form of Member's benefit plan.

EXHIBIT F

DENTAL CARE SERVICES

PAYMENT AND FEE SCHEDULE

This schedule establishes Payment for covered professional dental services rendered to OHP/Medicaid recipients under this Agreement. Except as stated below with respect to Non-Material Changes, CareOregon may make changes to this Exhibit E and the Fee Schedule specifications as stated in Section 8.14 of the Agreement. CareOregon may make Non Material Changes to the Fee Schedule Specifications immediately upon notice to Provider. “Non-material Changes” shall mean routine updates to nationally recognized codes (for example, codes are replaced, retired, or split into two codes.)

CareOregon Fee Schedule

As of the effective date this Agreement, CareOregon Dental will reimburse Provider for Covered Services, One-Hundred-Fifty Percent (150%) of the current DMAP fee schedule at the time of service.

This Fee Schedule is for “clinic-based services” only and excludes “community-based services”.

DEFINITIONS

The following definitions shall be applicable to this Exhibit.

- A) **Clinic-Based Services.** Services that take place in our partners’ clinics or school-based health centers. In these situations, an individual patient’s needs are being addressed by a provider.
- A school-based health center is a permanent clinic located in a school that can provide a wide variety of health care services.
 - Clinic-based services include all OHP covered dental services.
- B) **Community-Based Services.** Services would be provided to every child, regardless of their insurance status. The community or population is the “patient”.
- Schools (e.g. school-based dental sealant programs)
School-based dental sealant programs are temporary mobile events and provide only dental screenings and sealants.
 - Head Start
 - WIC
 - Daycare Centers

All community-based services should be billed directly to D3. D3 is a partner organization who will be contracting for all of CareOregon’s community based services.

EXHIBIT F (Cont)

DENTAL CARE SERVICES

PAYMENT AND FEE SCHEDULE

COMPLIANCE AUDIT

CareOregon may audit Contracted Provider periodically and upon request Contracted Provider shall provide Records to CareOregon for the purpose of ensuring “community-based” claims have not been reimbursed by CareOregon. CareOregon desires open communication with Contracted Provider regarding CareOregon’s quality improvement initiatives and activities.

DENTAL QUALITY METRICS

New State of Oregon measurements (metrics) starting January 2016:

1. Dental sealants for 6-9 and 10-14 year olds: The state of Oregon now requires improvement in dental sealants for 6-9 and 10-14 year olds. Dental providers shall work with CareOregon Dental and their members to meet state requirements.
2. Dental assessments for children entering foster care. The state of Oregon now requires a dental assessment for children within 60 days of entry into the foster care system. Dental providers will work with CareOregon Dental and their members to meet state requirements.

Dental providers will be informed by CareOregon Dental as additional metrics are implemented by the State of Oregon. Dental providers shall work with CareOregon Dental and their members to meet all state requirements.

EXHIBIT G

PCP CAPACITY AND MEMBER ASSIGNMENT

Provider Capacity shall be as agreed upon in writing by the authorized representatives of the parties hereto.

Provider shall accept assignments of new Members from CareOregon until a minimum assignment of not less than the Provider Capacity shall have been reached. Thereafter, at any time Provider falls below the Provider Capacity, CareOregon may assign Member(s) from time-to-time to Provider pursuant to CareOregon's policies and procedures for Member assignment. Provider and CareOregon shall work cooperatively together to determine whether CareOregon's records of Member assignment accurately reflect Provider's current patient mix (for example, often individuals assigned to a provider do not actually become patients of Provider and should not be counted towards Provider Capacity).