

June 23, 2016

Board of Commissioners
Clackamas County

Members of the Board:

Approval of a Revenue Agreement with Health Share of Oregon for Behavioral Health services
to members enrolled the Oregon Health Plan (OHP)

Purpose/Outcomes	The purpose of this agreement is to provide Behavioral Health Services to Health Share of Oregon members enrolled in the Oregon Health Plan (OHP).
Dollar Amount and Fiscal Impact	The total amount of the agreement is unknown, because the number of clients who will be enrolled in OHP and assigned to Clackamas County Health Centers Division (CCHCD) cannot be projected with certainty. No County General funds are involved.
Funding Source	Health Center Clinics
Duration	July 1, 2016 – Until Terminated
Previous Board Action	No Previous Board Action
Strategic Plan Alignment	1. Efficient and effective Services 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 Health Share of Oregon for the purpose of providing Behavioral Health Services.

This agreement will allow Health Share to refer their clients enrolled in the Oregon Health Plan (OHP) 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 July 1, 2016 and will continue until terminated. This document was reviewed by County Counsel on June 9, 2016.

Recommendation

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

Respectfully submitted,

Richard Swift, Director
Health, Housing & Human Services

HEALTH SHARE OF OREGON
PROVIDER PARTICIPATION AGREEMENT

This Provider Participation Agreement (“Agreement”) is made and entered into as of July 1, 2016 (“Effective Date”), by and between Health Share of Oregon, an Oregon nonprofit corporation (“Health Share”), and Clackamas County acting by and through its Health, Housing and Human Services Department, Health Centers Division (“Provider”).

RECITALS

A. Health Share is a nonprofit organization that operates as a coordinated care organization as such term is defined under Oregon law (“CCO”), and as such, Health Share coordinates health care coverage for enrollees of the Oregon Health Plan (“OHP”) or otherwise;

B. As a CCO, Health Share desires to provide Members with a broad network of high quality, efficient and convenient health care facilities, professionals, and other provider types from which Members may receive covered services;

C. Provider desires to provide covered services to Health Share Members; and

D. Health Share desires, in support of developing a network, to contract with Provider to become a participating provider in Health Share’s network; and Provider wishes to so participate in Health Share’s network and to fully cooperate with Health Share and other Health Share providers in supporting Health Share’s goals, all in accordance with the terms and conditions set forth in this Agreement.

AGREEMENT

NOW, THEREFORE, in consideration of the above Recitals and the mutual covenants and promises contained herein, Health Share and Provider agree as follows:

ARTICLE I
DEFINITIONS

“**Contracted Services**” has the meaning given to that term in Section 2.1.

“**Covered Service**” means health care services and supplies that are Medically Necessary and for which benefits are available under a Member’s Plan.

“**Medically Necessary**” means services and medical supplies required for prevention, diagnosis or treatment of a health condition that encompasses physical or mental conditions, or injuries and are (a) consistent with the symptoms of a health condition or treatment of a health condition; (b) appropriate with regard to standards of good medical practice and generally recognized by the relevant scientific community and professional standards of care as effective; (c) not solely for the convenience of a Member or a provider of the service or medical supplies, and; (d) the most cost effective of the alternative levels of medical services or medical supplies that can be safely provided to a Member.

“Member” means a person who is enrolled in a Plan with Health Share, generally identifiable through a Health Share identification card issued to the person, and who is eligible to receive Covered Services.

“PHI” has the meaning given to that term in Section 2.1.

“Plan” means the contract or arrangement that has been established with Health Share, including contracts or arrangements established by federal and state governmental programs, that entitles Members to receive specific Covered Services through Health Share.

“Provider Manual” means a separate reference source developed by Health Share that contains written policies and procedures and other information that Provider will need to know to perform its obligations under this Agreement. The manual may include, but is not limited to, information pertaining to payment, reimbursement, credentialing, medical policy, utilization management, quality improvement, fraud and abuse, health benefit plan standards, service authorization requests, member rights, third-party recovery, evidence-based clinical practice guidelines, privacy, security, care integration and coordination activities, audit rights of Health Share and RAEs, overpayment recoveries, and such other matters determined from time to time by Health Share and RAEs.

“Practitioners” has the meaning given to that term in Section 2.3.

“Provider Qualifications” has the meaning given to that term in Section 2.9.

“Records” has the meaning given to that term in Section 2.13.

“Risk Accepting Entity” or **“RAE”** means the individual entities that have entered into a Risk Accepting Entity Participation Agreement with Health Share in exchange for a per member per-month payment described in the same agreement. The entities defined as RAEs, which may change from time-to-time, are listed in Exhibit A. Health Share Members will be assigned to a particular RAE.

ARTICLE II OBLIGATIONS AND REPRESENTATIONS OF PROVIDER

2.1 Covered Services. Provider will accept Members as patients and provide to Members the Covered Services listed in the attached and incorporated herein Covered Services and Compensation Addendum(s) of this Agreement that are Medically Necessary (the “Contracted Services”). Provider will provide those Contracted Services to Members in an amount, duration and scope that is not less than the amount, duration and scope for the same services provided by Provider to other individuals who receive services equivalent to those Contracted Services. The facilities at which Provider will provide Covered Services to Members are listed in Exhibit B. Provider will ensure that Contracted Services rendered by Provider: (i) are within the scope of, and in accord with, the Provider’s and Practitioner’s license and certifications, (ii) are within the scope of privileges granted by Health Share or the applicable RAE, and (iii) meet the community professional standards relevant to the services provided. Provider acknowledges that the rights of Members to receive particular services is governed by the terms of the relevant Plan covering the Members.

2.2 RAE Access to Provider Services. Provider acknowledges and agrees that under the requirements of this Agreement, Provider will provide Contracted Services on behalf of either Health Share or the applicable RAE to which a Member is assigned. Provider will cooperate in good faith with Health Share and each RAE in providing the Contracted Services to Members under this Agreement.

2.3 Practitioners. Provider will ensure that all of Provider's employed and contracted professionals who provide Contracted Services to Members (the "Practitioners"): (i) comply with all of the terms and conditions of this Agreement (unless the context requires otherwise), (ii) are credentialed by Provider prior to providing services to Members and meet Health Share's credentialing and recredentialing requirements, and (iii) comply with all requests for information from Health Share related to Practitioners' qualifications. Provider will not bill for or be entitled to receive any compensation for providing any services that are inconsistent with the privileges granted to a particular Practitioner. Provider will be solely responsible for payment of all wages, salary, compensation, payroll and withholding taxes, unemployment insurance, workers' compensation coverage and all other compensation, insurance and benefits with respect to Practitioners.

2.4 Hours of Operation. Provider will arrange for provision of Contracted Services during normal office hours that are not less than the hours of operation offered to Provider's other patients.

2.5 Care Integration and Coordination. Provider will support Health Share and RAE in the implementation of care integration and coordination activities to develop, support and promote Health Share's and RAE's efforts to integrate and coordinate care among providers to create a continuum of care that integrates mental health, addiction treatment, dental health, physical health and community-based interventions seamlessly and holistically. Provider will also participate with Health Share and RAE in the implementation of evidence based clinical practice guidelines. Provider will consult with and comply with the Provider Manual related to the referral of Members to other providers for services.

2.6 Equipment and Supplies. At Provider's own cost and expense, Provider will supply the required personnel, equipment, instruments and supplies required to perform the Covered Services. Provider will ensure that all medical equipment used by Provider in rendering Covered Services: (i) meets the community standards as the appropriate equipment to be used for the services provided, (ii) is in good working order, (iii) is maintained in accord with the equipment manufacturer's schedule for service and maintenance, and (iv) is utilized or operated only by individuals or technicians with appropriate training and qualifications to operate such equipment. Provider will not bill for or be entitled to receive any compensation for providing any services if the Provider's use of the equipment does not meet the requirements of this Section 2.6.

2.7 Compliance with Provider Manual. Health Share shall make available to Provider its Provider Manual, incorporated by reference herein, electronically or, by request, in paper form. Provider agrees to comply with the policies and procedures set forth in the Provider Manual and understands that compliance is necessary to meet the obligations under this Agreement. Health Share may revise and update the Provider Manual from time to time with thirty (30) days' notice to Provider. Provider agrees that such revisions will become part of the Provider Manual and binding on Provider at the end of the 30 day notice period. Notwithstanding the foregoing, the parties understand that if there are any conflicts between the Provider Manual and the Agreement, this Agreement will prevail.

2.8 Reporting Responsibilities. Provider agrees to promptly provide any reports, information, or documents reasonably requested by Health Share or RAE in the form and format requested by Health Share or RAE. Such reports may include without limitation, reports regarding utilization, performance measures, quality metrics, Member satisfaction, coordination, expenses and savings. Provider represents and warrants that any reports and data provided pursuant to this Section 2.8 shall be accurate and complete.

2.9 Qualifications. At all times during the term of this Agreement, Provider shall meet each of the following qualifications (“**Provider Qualifications**”) and ensure that all Practitioners meet those qualifications:

2.9.1 Has and maintains in good standing all required or appropriate state and federal licenses, permits, registrations, certifications, approvals and authorizations to provide Covered Services under this Agreement consistent with state licensure requirements, Medicaid certification and other professional qualifications. Provider shall furnish evidence of the same to Health Share on request;

2.9.2 Has never been, and is not currently, suspended, debarred, or excluded from any federal or state funded health care program or from participating in any government procurement or non-procurement contract;

2.9.3 Provider shall comply with Health Share’s credentialing or recredentialing criteria then in effect. Provider shall promptly provide information required by Health Share to conduct credentialing or recredentialing.

2.9.4 Provider will, if applicable, ensure that each Practitioner: (i) meets all requirements for, obtain, and maintain a medical staff appointment and appropriate clinical privileges at a hospital affiliated with Health Share in accordance with such hospital’s medical staff bylaws, if applicable; and (ii) complies with such hospital’s credentialing policies and procedures and provides all credentials and other necessary information and documents required thereunder to Health Share or its designated agent upon request.

2.9.5 If compliance with any provision of this Agreement would result in the Provider’s or Practitioner’s loss of license, Provider agrees to notify Health Share within thirty (30) days of discovery of such conflict. Provider shall promptly notify Health Share of any action against Provider’s or any Practitioner’s professional license to practice, including but not limited to suspension, revocation or probation. Provider shall also promptly notify Health Share if he or she is convicted of a felony or expelled or suspended from the Medicaid program.

2.10 Representations and Warranties. Provider represents and warrants to Health Share the following, which warranties are in addition to, and not in lieu of, any other warranties provided herein:

2.10.1 Provider has the power and authority to enter into and perform the obligations described in this Agreement;

2.10.2 This Agreement, when executed and delivered, shall be a valid and binding obligation of Provider enforceable in accordance with its terms;

2.10.3 Provider has the skill and knowledge possessed by well-informed members of its industry, trade or profession and Provider will apply that skill and knowledge with care and diligence to perform the Work in a professional manner and in accordance with standards prevalent in Provider's industry, trade or profession; and

2.10.4 Provider shall, at all times during the term of this Agreement, be qualified, professionally competent, and duly licensed to perform the Covered Services.

2.11 External Quality Review; Access to Records and Facilities. Provider shall cooperate 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, Covered Services provided under this Agreement. If copies of such records are required, Provider shall provide those copies at no charge. Provider shall provide timely access to records and facilities and cooperate with Health Share in the collection of information through consumer surveys, on-site reviews, medical chart reviews, financial reporting and financial record reviews, interviews with staff, and other information for the purposes of monitoring compliance with this Agreement, including but not limited to verification of services actually provided, and for developing and monitoring performance and outcomes. Provider and Health Share agree to cooperate to ensure that the confidentiality restrictions in 42 C.F.R. Part 2-Confidentiality of Alcohol and Drug Abuse Patient Records, as may be amended from time to time ("42 C.F.R. Part 2"), are complied with prior to any review. The requirements described in this Section 2.11 shall survive termination of the Agreement.

2.12 Medical Records. Provider shall develop and maintain a medical record keeping system that:

2.12.1 Includes sufficient detail and clarity to permit internal and external review to validate encounter submissions and to assure Medically Necessary services are provided consistent with the documented needs of the Member;

2.12.2 Conforms to accepted professional practice; and

2.12.3 Allows Health Share and RAEs to ensure that data received from Provider 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.

2.13 Record Retention.

2.13.1 Provider shall retain, and shall cause its personnel to retain, clinical records for seven (7) years after the date of service for which claims are made. If an audit, litigation, research and evaluation, or other action involving the records is started before the end of the seven-year period, Provider shall retain, and shall cause its personnel to retain, the clinical records until all issues arising out of the action are resolved.

2.13.2 Provider shall maintain all financial records related to this Contract in accordance with generally accepted accounting principles. In addition, Provider shall maintain any other records, books, documents, papers, plans, records of shipment and payments and writings of Provider, whether in paper, electronic or other form, that are pertinent to this Contract in such a manner to clearly document Provider's performance. All financial records, other records, books, documents, papers, plans, records of shipments and payments and writings of Provider whether in paper, electronic or other form, that are pertinent to this Contract, are collectively referred to as "**Records.**" Provider acknowledges and agrees that OHA, the Secretary of State's Office, CMS, the Comptroller General of the United States, the Oregon Department of Justice Medicaid Fraud Control Unit and their duly authorized representatives shall have access to all Records to perform examinations and audits and make excerpts and transcripts. Provider shall retain and keep accessible all Records for the longer of: (i) six (6) years following final payment and termination of this Agreement; (ii) the retention period specified in this Agreement for certain kinds of records; (iii) the period as may be required by applicable law, including the records retention schedules set forth in OAR Chapters 410 and 166; or (iv) until the conclusion of any audit, controversy or litigation arising out of or related to this Agreement.

2.14 Business Associate Agreement; Consent to Disclose, Redisclose. Provider acknowledges and agrees that protected health information ("PHI") disclosed by Provider to Health Share may be used by or disclosed to RAE pursuant to a business associate agreement between those parties when permissible by law or pursuant to a written consent in compliance with 42 C.F.R. Part 2, as may be amended from time to time. Notwithstanding the foregoing, Health Share and Provider agree to comply with any and all applicable privacy laws including without limitation, 42 C.F.R. Part 2.

2.14.1 Provider will obtain Member's written consent, as required by 42 C.F.R. Part 2 and as may be specified by Health Share, to allow Member's patient identifying information to be disclosed by Provider to the RAEs and redisclosed by the RAEs to Health Share and the State of Oregon, only as such disclosure and redisclosure is required by this Agreement, Oregon law, and at Health Share's reasonable request.

2.15 Subrogation. Provider will subrogate to Health Share any and all claims Provider has or may have against any third parties related to the Contracted Services provided to Members, including 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.

2.16 Compliance with Applicable Law. Provider shall comply and cause all its personnel to comply with all Federal, State and local laws, regulations, executive orders and ordinances.

2.17 Informed Consent; Dignity and Respect. Provider shall inform Members about available treatment options and alternatives in a manner appropriate to the Member's condition and ability to understand. Provider shall ensure that its personnel treat Members with respect and with due consideration for their dignity and privacy to the same extent as all of Provider's other patients who receive services equivalent to Covered Services.

2.18 Prior Authorization. Provider acknowledges that in order for coverage to be in effect and to qualify for payment under the applicable Plan, some Contracted Services may be subject to

prior authorization. Provider will comply with policies and procedures related to prior authorization included in the Provider Manual, and will not be entitled to receive any compensation if the Provider fails to comply with those policies and procedures.

2.19 Grievances. Provider and Provider's Practitioners will comply with the grievance policies and procedures outlined in the Provider Manual.

2.20 Non-Covered Services. Provider will advise Member of any service, treatment, or test that that is recommended as medically appropriate for the Members in accord with the community standards of the medical profession, even if the service, treatment, or test is not covered under the Plan. This Agreement, and the fact of whether the Plan happens to provide coverage of any particular service, treatment or test, does not alter a Provider's duty to exercise professional skill and judgment in accord with the prevailing community standards applicable to Provider in advising and treating Members relative to that service, treatment, or test. Provider acknowledges that this Agreement may not be interpreted to require Provider to deny care to a Member for services that are not covered under the Plan. Provider will not bill Member for any service, treatment, or test not covered by the Plan unless all of the following conditions have been met: (i) Provider has provided a clear written disclosure in advance to the Member indicating that the service, treatment or test is not covered by the Plan; (ii) Provider has obtained a written consent from the Member acknowledging that the service, treatment or test is not covered and consenting to the service; (iii) such billing is permitted under the Plan; and (iv) such billing is not prohibited by law.

2.21 Nondiscrimination. Provider will not discriminate in the provision of services to Members on the basis of enrollment in the Plan, race, color, national origin, ethnicity, ancestry, religion, sex, marital status, sexual orientation, mental or physical disability, medical condition or history, age or any other category protected under state or federal law.

2.22 Compliance with Health Care Programs. Provider acknowledges that Provider is subject to, and will comply with utilization management, quality assurance, and fraud and abuse programs of Health Share and RAEs. Provider and Provider's Practitioners agree to cooperate with the Medical Directors of Health Share and the RAEs in the Medical Directors' review of, and in the establishment of programs, policies and procedures to, improve the quality of care delivered to Members.

2.23 Provider Directories of Health Share and RAEs. Provider agrees that Health Share and RAEs may use information about Provider and Provider's Practitioners in written or web site-accessible directories of participating providers. Such information includes the names, addresses, phone numbers, web sites, credentials, and other related information about Provider and Provider's Practitioners.

2.24 Oregon Health Plan Addendum. The terms and conditions set forth in the attached Oregon Health Plan Addendum are incorporated and made a part of this Agreement.

ARTICLE III COMPENSATION AND BILLING

3.1 Compensation. Health Share shall develop and maintain a schedule of payment methodologies and compensation for the Covered Services that Provider provides under this

Agreement, which is set forth in the Covered Services and Compensation Addendum(s) attached to and incorporated to this Agreement. Provider shall be entitled to the amounts and types of compensation described in that Addendum for furnishing Covered Services to Members in accordance with the terms and conditions of this Agreement. Provider agrees to accept as payment in full for Covered Services furnished to Members the compensation described in this Agreement.

3.2 Billing. Provider will be solely responsible to bill and collect for the provision of Covered Services under this Agreement. The primary payer for any compensation owed to Provider is the RAE to which the Member who received the Covered Services is assigned. Provider shall bill and collect for Covered Services in accordance with the following:

3.2.1 Provider shall comply with all relevant policies and procedures regarding billing, coding, claim submission, clean claims, overpayment recovery, audits, documentation, and any other matter related to claims for compensation as described in the Provider Manual.

3.2.2 Provider shall submit claims for Covered Services including all the fields and information needed to allow the claim to be processed without further information from Provider, and within time frames that assure all corrections have been made within one hundred twenty (120) days of the date of service.

3.2.3 Except as specifically permitted by this Agreement, including Third Party Resource recovery, Provider and its personnel may not be compensated for Covered Services performed under this Agreement from any other department of the State, nor from any other source including the federal government.

3.2.4 Provider and Provider's Practitioners will seek only to obtain compensation for Covered Services from the Members' applicable RAE, and at no time will seek compensation from Members other than for those items set forth in the Plan, such as applicable copayments, coinsurance and deductible amounts. In the event of non-payment by Health Share or the applicable RAE for any reason, Provider and Provider's Practitioners will not bill or otherwise attempt to collect any amounts owed.

3.2.5 Provider will bill and make reasonable efforts to collect any copayments, coinsurance and deductibles from Members in accord with the terms of the Plan.

3.3 Coordination of Benefits. Provider agrees to abide by policies and procedures for coordination of benefits, duplicate coverage and third-party liability policies as described in the Provider Manual. If any services to which Members are entitled are also covered under any other group or non-group health plan, prepaid medical plan, insurance policy or Workers' Compensation, Provider and the applicable RAE shall cooperate in the investigation of all such benefits so that Health Share or RAE shall bear no more of the total cost than is required by this Agreement or by the law of the state in which Provider practices. Except as otherwise set forth herein, Provider agrees to accept the negotiated amount as payment in full, whether that amount is paid in whole or in part by the Member, RAE or Health Share, or by any combination of payers, including other payers which may pay before Health Share or RAE in the order of benefit determination.

**ARTICLE IV
RELATIONSHIP OF THE PARTIES**

4.1 Independent Parties. The parties to this Agreement are independent parties, and nothing in this Agreement shall be construed or be deemed to create between them any relationship of principal and agent, partnership, joint venture, or any relationship other than that of independent parties. No party hereto, nor the respective agents or employees of either party, shall be required to assume or bear any responsibility for the acts or omissions, or any consequences thereof of the other party under this Agreement. No party hereto, nor the respective agents or employees of either party, shall be liable to other persons for any act or omission of the other party in performance of their respective responsibilities under this Agreement.

4.2 Tax Obligations. Provider shall be responsible for appropriate management of all federal and state obligations applicable to compensation or payments paid to Provider under this Agreement.

**ARTICLE V
TERM AND TERMINATION**

5.1 Term of Agreement. When executed by both parties, this Agreement shall become effective as of the Effective Date and shall continue in effect until terminated pursuant to this Agreement.

5.2 Termination on Default. In the event Health Share or Provider should materially default in the performance of any obligation imposed on it by this Agreement, the non-defaulting party shall elect to provide the defaulting party with written notice describing the facts and circumstances of the default. After providing such notice, the non-defaulting party may elect, by written notice to the defaulting party, to terminate this Agreement if the defaulting party has not cured any default within thirty (30) days following the defaulting party's receipt of the applicable default notice; provided, however that with respect to any default covered by this subsection which reasonably requires additional time to cure, such failure shall not result in a termination of the Agreement so long as the defaulting party has commenced performance of a cure within the stated cure period and diligently pursues such cure to completion.

5.3 Immediate Termination by Health Share. Notwithstanding any other term herein to the contrary, Health Share may immediately terminate this Agreement or the participation of any individual health care provider providing services for Provider pursuant to this Agreement on delivery of written notice to Provider if any of the following occurs:

5.3.1 Provider does not fully meet all Provider Qualifications set forth in Section 2.9 of this Agreement;

5.3.2 Any of Provider's contracted, employed, leased, owned or controlled personnel providing or assisting in the provision of Covered Services is excluded, debarred, suspended or declared ineligible to participate in any federal health care program, or in any federal procurement or non-procurement program;

5.3.3 Provider receives a criminal conviction of any kind.

5.3.4 The dissolution, reorganization or sale of or change in control of Provider.

5.3.5 If Provider: (i) voluntarily files a petition in or for bankruptcy or reorganization; (ii) makes a general assignment or another arrangement for the benefit of creditors; (iii) is adjudged bankrupt; (iv) has a trustee, receiver or other custodian appointed on its behalf; or (v) has any other case or proceeding under any bankruptcy or insolvency law, or any dissolution or liquidation proceeding commenced against it.

5.3.6 Provider fails or refuses to provide or arrange for the provision of Covered Services to Members in a professionally acceptable manner.

5.3.7 Professional liability insurance covering Provider, as required by this Agreement, is terminated without replacement coverage being obtained in amounts required by this Agreement.

5.3.8 Provider's knowing or deliberate submission of false or misleading billing information to Health Share or any RAE.

5.3.9 Health Share determines in its sole discretion that Provider is in violation of or has failed to comply with any of the requirements of this Agreement that are not curable by Provider due to their nature.

5.4 Termination without Cause. The parties agree that they are contracting at will. Either Health Share or Provider may terminate this Agreement without cause upon ninety (90) days' advance written notice to the other party. However, such termination shall not relieve either party of any contractual obligation(s) incurred prior to the Effective Date of the termination.

5.5 Change in Law. In the event state or federal laws are enacted, or state or federal regulations are promulgated which, in the opinion of Health Share, make this Agreement illegal under such laws or regulations, or this Agreement is otherwise deemed by appropriate state or federal governmental authorities to violate such laws or regulations, this Agreement shall be immediately amended to comply with such laws or regulations or be terminated.

5.6 Continuity of Care. In the event of termination of this Agreement, the following provisions shall apply to ensure continuity of the Covered Services to Members. Provider shall ensure:

5.6.1 Continuation of Covered Services to Member for the period during which RAE has paid Compensation to Provider, including inpatient admissions up until discharge;

5.6.2 Orderly and reasonable transfer of Member care in progress, whether or not those Members are hospitalized;

5.6.3 Timely submission of information, reports and records, including encounter data, required to be provided to Health Share and RAEs during the term of this Agreement;

5.6.4 Timely payment of valid claims for services to Members for dates of service included within the term of the Agreement; and

5.6.5 If Provider continues to provide services to a Member after the date of termination of this Agreement, Health Share shall have no responsibility to pay for such services to notify Members of the termination of this Agreement and to direct Members to other participating providers.

ARTICLE VI INDEMNIFICATION

6. Indemnification. To the extent permitted by Article XI, Section 7 of the Oregon Constitution and by Oregon Tort Claims Act, Provider shall defend, indemnify and hold harmless: (i) Health Share, (ii) the RAEs, and (iii) Health Share's and RAE's directors, officers, employees, affiliates and agents against any claim, loss, damage, cost, expense or liability arising out of or related to (i) Provider's breach of this Agreement, (ii) the Provider's, Practitioners' or Provider's officers, directors, shareholders and employees, affiliates and agents (collectively "Provider Parties") gross negligence or willful misconduct, (iii) malpractice or other errors and omission by Provider, Provider Parties' or Practitioners' provision of medical or health care goods and/or services, and (iv) the performance or nonperformance by Provider, Practitioners or Provider Parties of any Contracted Services and other services to be performed or arranged by Provider under this Agreement. Health Share shall defend, indemnify and hold harmless Provider and Provider's Parties against any claim, loss, damage, cost, expense or liability arising out of or related to (i) Health Share's breach of this Agreement, and (ii) the performance or nonperformance by Health Share under this agreement.

ARTICLE VII INSURANCE

7.1 Insurance. Pursuant to Health Share policies and procedures, Provider shall maintain, at Provider's sole expense, and keep in force, insurance policies, providing comprehensive general liability and professional liability or any other insurance as may be necessary to insure Provider and its officers, directors, agents and employees against any claim or claims for damages arising out of the providing of, or failure to provide, Covered Services pursuant to this Agreement. Evidence of insurance coverage required under this Section will be made available to Health Share on request. Provider will provide Health Share at least fifteen (15) days' advance written notice of revocation, suspension, reduction, limitation, probationary or other disciplinary action taken on any of Provider's required insurance coverage.

7.2 Claims, Incidents, Suits and Disciplinary Actions. Provider agrees to promptly report to Health Share any claim made, suit filed or disciplinary action commenced against Provider or its personnel relating to the provision of Covered Services under this Agreement.

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

ARTICLE VIII DISPUTES AND COMPLAINTS

8.1 Arbitration. Except as otherwise provided in Section 8.2, any dispute, controversy, or claim arising out of the subject matter of this Agreement will be settled by arbitration before a single arbitrator in Portland, Oregon. If the parties agree on an arbitrator, the arbitration will be held before the arbitrator selected by the parties. If the parties do not agree on an arbitrator, each party will designate an arbitrator and the arbitration will be held before a third arbitrator selected by the designated arbitrators. Each arbitrator will be an attorney knowledgeable in the area of business and healthcare law. The arbitration will be initiated by filing a claim with Arbitration Service of Portland and will be conducted in accordance with the then-current rules of Arbitration Service of Portland. The resolution of any dispute, controversy, or claim as determined by the arbitrator will be binding on the parties. Judgment on the award of the arbitrator may be entered by any party in any court having jurisdiction.

8.2 Compelling Arbitration. A party may seek from a court an order to compel arbitration, or any other interim relief or provisional remedies pending an arbitrator's resolution of any dispute, controversy, or claim. Any such action, suit, or proceeding will be litigated in courts located in Multnomah County, Oregon. For the purposes of the preceding sentence, each party consents and submits to the jurisdiction of any local, state, or federal court located in Multnomah County, Oregon. If a claim must be brought in a federal forum, then it shall be conducted solely and exclusively within the United States District Court for the District of Oregon.

8.3 Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the State of Oregon without regard to principles of conflicts of law.

ARTICLE IX GENERAL PROVISIONS

9.1 Amendments.

9.1.1 Mutual Amendment. The terms of this Agreement may be amended from time to time in a writing signed by Health Share and Provider.

9.1.2 Notice Amendments. Health Share may amend this Agreement by providing sixty (60) calendar days written notice to Provider of the amendment to the Agreement ("Notice Amendment"). Provider may reject Notice Amendments by terminating this Agreement in accordance with terms for termination described above. If no notice of termination is received by Health Share, Notice Amendments shall be binding upon Provider at the end of the sixty (60) calendar-day period, and this Agreement shall be deemed amended as of that date, or as of the date specified in the Notice Amendment, even if not signed by Provider. The aforementioned notice requirements do not apply to policies and procedures included in the Provider Manual that may be updated from time to time. Such policies and procedures will be available to Providers via the Provider Manual which will be accessible electronically or on request by Provider.

9.1.3 Amendments Required by Law. Health Share may modify this Agreement immediately to comply with changes in state or federal laws or regulations, as described in Section 5.5 of this Agreement. Such amendments do not require consent of Provider and will be effective

immediately on notice to Provider of the effective date thereof. Health Share will provide notice to Provider of such amendments as soon as reasonably possible.

9.2 Notices and Communications between the Parties.

9.2.1 Certain Notices Required Under This Agreement. The following notices must be sent via overnight delivery with delivery confirmation or certified mail, return receipt requested:

- (a) All notices for termination of this Agreement; and
- (b) All requests for mediation and/or arbitration.

9.2.2 All Other Notices and Communications. All other notices and communications between the parties which are necessary for the proper administration of this Agreement (including notices required within this Agreement which are not included in Section 9.2.1 above) may be communicated via regular U.S. mail, confirmed facsimile or electronic mail.

9.2.3 Confidential and Protected Health Information. If a notice or communication includes information which is confidential or proprietary to either or both parties and/or which includes PHI as defined under HIPAA, then the following restrictions must be observed when communicating such information:

- (a) U.S. Mail/Certified Mail/Overnight Delivery: no additional requirements.
- (b) Facsimile Transmission: The information must be prefaced by a formal cover sheet noting the confidentiality of such information.
- (c) Web Site: Not a permitted method of notice or communication for confidential information and PHI, unless the Web Site is secure or the information appropriately encrypted.
- (d) Electronic Mail: Not a permitted method of notice or communication for confidential information and PHI, unless the electronic mail is secured or the information is appropriately encrypted.

9.2.4 Address for Notices. Notices to Provider shall be sent to: (i) the facsimile or postal address of Providers billing service location or any other revised postal address or facsimile provided by Provider to Health Share in writing; or (ii) the electronic mail address designated by Provider for electronic notices. Notices to Health Share shall be sent to:

Health Share of Oregon
2121 SW Broadway, Suite 200
Portland, Oregon 97201
Attention: Contract Department

Or any revised address provided to Provider in writing. The facsimile, postal address or electronic mail address for notice may be changes on prior written notice to the other party.

9.2.5 When Made. For notices described under Section 9.2.1 above, the notice will be deemed to have been made on the date it was delivered. For notices and communications described under Section 9.2.2, the notice or communication will be deemed to have been made when sent or emailed.

9.3 Assignment of Contract, Successors in Interest.

9.3.1 Health Share shall be permitted to assign or transfer its interest in this Agreement without prior consent of Provider.

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

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

9.5 Entire Agreement; Amendments. This Agreement and Exhibits constitute the full and complete expression of the rights and obligations of the parties with respect to the subject matter and supersedes all prior understandings and agreements, whether oral or written. This Agreement may only be amended pursuant to the provisions described in Section 9.1.

9.6 Confidential Business Information. Provider agrees not to disclose to any third party any confidential business information or trade secrets that are disclosed to it as a result of its participation in this Agreement. "Confidential Information" shall mean all information provided by one party to this Agreement to another in connection with this Agreement, which is designated as "Confidential." Confidential Information includes, without limitation, information relating to a Party's trade secrets, research and development, inventions, know-how, software (including source code and object code), procedures, purchasing, accounting, marketing, patients, customers, suppliers, financial status or employees whether designated as "Confidential" or not. Each party agrees that it will not make use of, disseminate, disclose or in any way circulate any Confidential Information supplied to or obtained by it in writing, orally or by observation, except as expressly permitted by this Agreement or as required by law or order of a court or administrative agency having jurisdiction. Confidential Information may be used as necessary to perform the services required under this Agreement and may be disclosed by a party to this Agreement to its own employees that require access to such Confidential Information for the purposes of this Agreement. This paragraph does not prevent disclosure in connection with an audit or survey in the normal course of business by regulatory authorities, certified public accountants, accrediting institutions and the like; provided the recipient is under a duty to protect the confidentiality of the information disclosed.

9.7 Waiver. The waiver of any provision of this Agreement shall only be effective if set forth in writing and signed by the waiving party. Any such or other waiver shall not operate as, or be deemed to be, a continuing waiver of the same or of any other provision of this Agreement.

9.8 Third-Party Rights. The parties do not intend the benefits of this Agreement to inure to any third person not a signatory to this Agreement. The Agreement shall not be construed as creating any right, claim, or cause of action against any party by any person or entity not a party to this Agreement except as otherwise described in this Agreement.

9.9 Counterparts. This Agreement may be executed in any number of counterparts, each of which shall be deemed an original, but all counterparts together shall constitute one and the same instrument.

The foregoing terms are agreed to by the parties.

Execution Date: _____

Health Share of Oregon

Provider

By: _____

By: _____

Name: _____

Name: _____

Title: _____

Title: _____

TIN: _____

EXHIBIT A

Health Share of Oregon Risk Accepting Entities

As of the Effective Date of this Agreement, listed below are the Risk Accepting Entities (RAEs) which have access to the services provided by Provider, as referenced in Section 2.1, to the extent Provider provides the type of Covered Services required by RAEs assigned Health Share Members. Health Share shall notify Provider if this list changes.

CareOregon, Inc.
Kaiser Foundation Health Plan
Providence Health Assurance
Tuality Health Alliance
Clackamas County
Multnomah County
Washington County
Access Dental Plan, LLC
Advantage Dental
Capitol Dental Care, Inc.
Family Dental Care
Managed Dental Care of Oregon, Inc.
ODS Community Health, Inc.
Willamette Dental Group

EXHIBIT B
List of Facilities

As of the Effective Date of this Agreement, listed below are the facilities owned and operated by Provider which shall provide Contracted Services pursuant to this Agreement. Provider shall notify Health Share if this list changes.

Behavioral Health:

Oregon City Hilltop Center
998 Library Court
Oregon City, OR 97045
Mon. – Fri. 8:00AM – 6:30PM

Sandy Center Behavioral Health
38872 Proctor Blvd.
Sandy, OR 97055
Mon. – Thur. 8:00AM – 6:30PM

Stewart Community Center
1002 Library Ct.
Oregon City, OR 97045-4065
Mon. – Fri. 8:00AM – 5:00PM

Crisis:

Centerstone Crisis
11211 SE 82nd Ave., suite O
Happy Valley, OR 87086-7624
Mon. – Fri. 9:00AM – 8:00PM
Sat. & Sun. 10:00PM – 7:00PM

Primary Care:

Beavercreek Clinic
1425 Beavercreek Rd.
Oregon City, OR 97045-4023
Mon. – Fri. 8:00AM – 7:00PM

Gladstone Clinic
18911 Portland Ave.
Gladstone, OR 97027-1630
Mon. 8:00AM – 7:00PM; Tue. 9:00AM – 5:00PM
Wed.–Fri. 8:00AM – 5:00PM

Sunnyside Health & Wellness Center
9775 SE Sunnyside Rd., Ste 200
Clackamas, OR 97015-5721
Mon – Friday 8:00AM – 7:00PM

Oregon City School Based Health Center
19761 S Beavercreek Rd.
Beavercreek, OR 97045
7:00AM - 3:00PM Everyday school is open

Canby School Based Health Center
721 SW 4th Ave.
Canby, OR 97013
7:00AM – 3:00PM Everyday school is open

Sandy School Based Health Center
37400 SE Bell St
Sandy, OR 97055
7:00AM – 3:00PM Everyday school is open

Sandy Health and Wellness Center
37400 SE Bell St
Sandy, OR 97055
Mon – Fri from 3.00PM – 8.00PM

Oregon Health Plan Addendum

This Oregon Health Plan Addendum (the “**OHP Addendum**”) is made part of the Provider Participation Agreement by and between Health Share of Oregon, an Oregon nonprofit corporation (“**Health Share**”), and Clackamas County, acting by and through its Health, Housing and Human Services Department, Health Centers Division (“**Provider**”). Health Share is a party to a Health Plan Services Contract, Coordinated Care Organization (the “**OHP Contract**”), with the State of Oregon, acting by and through the Oregon Health Authority (the “**OHA**”). The OHP Contract requires certain additional provisions to be included in the agreement between Health Share and Provider.

Provider will comply with and cause any Subcontractor of Provider to Comply with, all of the provisions in this OHP Addendum to the extent they are applicable to the services provided by Provider. If Provider subcontracts any functions of the Agreement, Provider will ensure that any subcontracts include all of the requirements set forth in this OHP Addendum. Capitalized terms used in this OHP Addendum that are not otherwise defined in this OHP Addendum or the Agreement have the meanings given to them in the OHP Contract. Health Share may undertake any duties under this Addendum either directly or through Health Share’s arrangement with a RAE. Similarly, Provider will cooperate with and afford to any RAE the same rights and obligations that the Provider owes to Health Share under the Agreement and the OHP Addendum. Therefore, references throughout this OHP Addendum to rights and obligations that Provider owes to Health Share should also be read to include an obligation to afford those same rights and obligations to a RAE, unless the context suggests otherwise. References to “Medically Necessary” in the main body of the Agreement have the same meaning as “Medically Appropriate,” as that term is defined under the statutes and regulations implementing the Oregon Health Plan.

1. **General Commitment to Comply with Terms of OHP Contract.** Provider has been given a copy of the OHP Contract. Provider agrees to comply with all requirements, terms, conditions, commitments, responsibilities, and obligations applicable to a “Subcontractor” or a “Participating Provider,” as those terms are defined and applied in the OHP Contract, to the extent they are applicable to the services provided by Provider under this Agreement.
2. **Compliance with Applicable Law.** Provider will comply with all Federal, State and local laws, regulations, executive orders and ordinances applicable to the OHP Contract or to the performance of services under the Agreement as they may be adopted, amended or repealed from time to time, including but not limited to the following: (i) ORS Chapter 659A.142; (ii) OHA rules pertaining to the provision of prepaid capitated health care and services, OAR Chapter 410, Division 141; (iii) all other OHA Rules in OAR Chapter 410; (iv) all other applicable requirements of State civil rights and rehabilitation statutes, rules and regulations; (v) Title VI and VII of the Civil Rights Act of 1964, as amended; (vi) 45 CFR Part 84 which implements Title V, Sections 503 and 504 of the Rehabilitation Act of 1973, as amended; (vii) the Americans with Disabilities Act of 1990, as amended; (viii) Executive Order 11246, as amended; (ix) the Health Insurance Portability and Accountability Act of 1996, as amended; (x) the Age Discrimination in Employment Act of 1967, as amended, and the Age Discrimination Act of 1975, as amended; (xi) the

Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended; (xii) all regulations and administrative rules established pursuant to the foregoing laws; (xiii) all other applicable requirements of federal civil rights and rehabilitation statutes, rules and regulations; and (xiv) all federal law governing operation of CMHPs, including without limitation, all federal laws requiring reporting of Client abuse.

3. **Covered Services.** Provider will provide Medically Appropriate health services described in ORS Chapter 414 and applicable administrative rules that are based on the Prioritized List of Health Services.
4. **Access to Records and Facilities.** Provider will maintain all financial records related to the OHP Contract in accordance with generally accepted accounting principles or National Association of Insurance Commissioners accounting standards. In addition, Provider will maintain any other records, books, documents, papers, plans, records of shipment and payments and writings of Provider, whether in paper, electronic or other form, that are pertinent to the OHP Contract in such a manner to clearly document Provider's performance. All financial records, other records, books, documents, papers, plans, records of shipments and payments and writings of Provider whether in paper, electronic or other form, that are pertinent to this Contract, are collectively referred to as "Records." Provider acknowledges and agrees that OHA, the Secretary of State's Office, CMS, the Comptroller General of the United States, the Oregon Department of Justice Medicaid Fraud Control Unit and their duly authorized representatives shall have access to all Records to perform examinations and audits and make excerpts and transcripts. Contractor shall retain and keep accessible all Records for the longer of: (i) Six years following final payment and termination of the OHP Contract; (ii) the retention period specified in this Agreement for certain kinds of records; (iii) The period as may be required by applicable law, including the records retention schedules set forth in OAR Chapters 410 and 166; or (iv) until the conclusion of any audit, controversy or litigation arising out of or related to the OHP Contract or the Agreement. Provider will, upon request and without charge, provide a suitable work area and copying capabilities to facilitate such a review or audit. The rights of access in this subsection are not limited to the required retention period, but shall last as long as the records are retained.
5. **No Billing for Non-Covered Services.** Provider will not bill Members for services that are not covered under the OHP 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.
6. **Acknowledgment of Receipt of Grievance System.** Provider acknowledges that Health Share provided to Provider a copy of OHA's approved written procedures for Health Share's grievance system.
7. **Performance Monitoring.** Provider will cooperate with Health Share's policies, procedures, and actions, and will comply with Health Share's request for information, documentation, reporting and access that permit Health Share to monitor the Provider's performance on an ongoing basis and to perform, at least once a year, a formal review of Provider's compliance with delegated responsibilities and performance, and to identify any deficiencies or areas for improvement, in accordance with 42 CFR 438.230. Upon

identification of deficiencies or areas for improvement, Provider will develop and implement a time specific plan for the correction of identified areas of noncompliance or substandard performance.

8. **Termination for Cause.** In addition to other remedies provided in the Agreement or provided at law, Health Share may terminate the Agreement or impose other sections if the Provider's performance is inadequate to meet the requirements of the OHP Contract.
9. **Federal Managed Care Requirements.** Provider will comply with the requirements of 42 CFR 438.6 that are applicable to any services or supplies provided by Provider under the Agreement.
10. **Prevention/Detection of Fraud & Abuse.** Provider will have fraud and abuse policies and procedures and a mandatory compliance plan, in accordance with in accordance with OAR 410-120-1510, 42 CFR 433.116, 42 CFR 438.214, 438.600 to 438.610, 438.808, 42 CFR 455.20, 455.104 through 455.106 and 42 CFR 1002.3, which enable Provider to prevent and detect fraud and abuse activities as such activities relate to the OHP. Provider will review Provider's fraud and abuse policies annually. Provider will promptly refer all suspected cases of fraud and abuse, including fraud by its employees and subcontractors to Health Share, the Medicaid Fraud Control Unit (MFCU) and the Provider Audit Unit of OHA (OHA/PAU).
11. **Cooperation with Fraud & Abuse Investigations.** Provider will cooperate, and requires its subcontractors to cooperate, with the MFCU and OHA/PAU investigator during any investigation of fraud or abuse. Provider will permit the MFCU or OHA/PAU or both to inspect, evaluate, or audit books, records, documents, files, accounts, and facilities maintained by or on behalf of Provider or by or on behalf of any subcontractor, as required to investigate an incident of fraud and abuse. Provider will provide copies of reports or other documentation regarding the suspected fraud or abuse at no cost to MFCU or OHA/PAU during an investigation.
12. **Abuse Reporting.** Provider will 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 rules associated with those statutes. Furthermore, Provider will 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. **Timely Access to Care.** Provider will 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 Provider offering hours of operation that are not less than the hours of operation offered to Provider's commercial patients (as applicable).
14. **Reporting of Preventive Services.** If Provider provides any Preventive Care Services, Provider will report all services provided to Members to Health Share or RAE to which the Member has been assigned for purposes of Health Share's or RAE's Medical Case Management and Record Keeping responsibilities.

15. **Reporting to AMH of Admissions or Discharges.** If the services provided by the Provider under this Agreement includes providing substance use disorder services or Mental Health Services, Provider will provide to AMH, within 30 days of admission or discharge, with all information required by AMH's most current reporting system, currently "Client Process Monitoring System" ("CPMS").
16. **Required Background and Training for Substance Use Disorders.** If the services provided by the Provider under this Agreement includes the evaluation of Members for access to and length of stay in substance use disorder services, Provider will ensure that Provider's personnel providing such services must have the training and background in substance use disorder services and working knowledge of American Society of Addiction Medicine ("ASAM") Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition-Revised ("PPC-2R"). Contractor shall participate with AMH in a review of AMH provided.
17. **Substance Use Disorder Personnel to Provide Information about Community Resources.** If the services provided by the Provider under this Agreement includes providing substance use disorder services, Provider will ensure that Provider's personnel providing such services will provide to Member, 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.
18. **No Adverse Treatment of Members Exercising Rights.** Provider will ensure that OHP Members are free to exercise their patient rights under Oregon law, and that the exercise of those rights will not adversely affect the way the Provider or Provider's personnel treat the Member. Provider will not discriminate in any way against Members when those Members exercise their rights under the OHP.
19. **No Marketing.** Provider may not initiate contact or Market independently to Potential Members, directly or through any agent or independent contractor, in an attempt to influence a Client's Enrollment with Health Share or any other entity, without the express written consent of OHA. Provider may not conduct, directly or indirectly, door-to-door, telephonic, mail, electronic, or other Cold Call Marketing practices to entice the Client to enroll with any entity, or to not enroll with another contractor. Provider may not seek to influence a Client's Enrollment with Health Share or any other entity in conjunction with the sale of any other insurance.
20. **Accommodation for Disability or Limited English.** Provider will be prepared to meet the special needs of Members who require accommodations because of a disability or limited English proficiency. will provide timely access to records and facilities and cooperate with OHA in collection of information through consumer surveys, onsite reviews, medical chart reviews, financial reporting and financial record reviews, interviews with staff, and other information for the purposes of monitoring compliance the OHP Contract, including but not limited to verification of services actually provided, and for developing and monitoring performance and outcomes.

21. **Access to Records and Cooperation with Information Collection Efforts.** Provider will provide timely access to records and facilities and cooperate with OHA in collection of information through consumer surveys, onsite reviews, medical chart reviews, financial reporting and financial record reviews, interviews with staff, and other information for the purposes of monitoring compliance with OHP Contract, including but not limited to verification of services actually provided, and for developing and monitoring performance and outcomes.
22. **Third Party Liability Recovery.** Provider will maintain records of any Providers actions related to Third Party Liability recovery, and make those records available for OHA review. Provider may not refuse to provide Covered Services, to a Member because of a Third Party potential liability for payment for the Covered Service. Provider will 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 Provider. Provider acknowledges that where Medicare and Health Share 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 Provider may be paid. Provider acknowledges that if the Third Party has reimbursed Health Share or Provider, or if a Member, after receiving payment from the Third Party Liability, has reimbursed Health Share or Provider, Health Share or Provider must reimburse Medicare up to the full amount that Health Share or Provider received, if Medicare is unable to recover its payment from the remainder of the Third Party Liability payment.
23. **Subrogation.** Provider agrees to subrogate to OHA any and all claims Provider has or may have against manufacturers, wholesale or retail suppliers, sales representatives, testing laboratories, or other providers in the design, manufacture, marketing, pricing, or quality of drugs, pharmaceuticals, medical supplies, medical devices, durable medical equipment, or other products.
24. **External Quality Review.** In conformance with 42 CFR 438 Subpart E, Provider will 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, the services provided under this Agreement and releasing its right to subrogation in a particular case.
25. **Sterilization and Hysterectomy Records.** Provider will, within 60 days of a request from OHA or Health Share, provide Health Share with a list of all Members who received sterilizations or hysterectomies, from Provider and copies of the informed consent form or certification. OHA and Health Share will be permitted to review the Medical Records of these individuals selected by OHA for purposes of determining compliance with OAR 410-130-0580.
26. **Produce Alternate Forms of Communication.** In compliance with the Americans with Disabilities Act, any written material that is generated and provided by Provider to reproduced in alternate formats of communication, to include Braille, large print, audiotape, oral presentation, and electronic format.

27. **Access to OHA Computer Systems.** If the services performed under this Agreement requires Provider 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, Provider will comply with OAR 407-014-0300 through OAR 407-014-0320, as such rules may be revised from time to time. For purposes of this section, “Information Asset” and “Network and Information System” have the meaning set forth in OAR 407-014-0305, as such rule may be revised from time to time.
28. **Equal Employment Opportunity.** Provider will 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).
29. **Clean Air, Clean Water, EPA Regulations.** Provider will 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, DHHS and the appropriate Regional Office of the Environmental Protection Agency.
30. **Energy Efficiency.** Provider will 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).
31. **Truth in Lobbying.** Provider certifies, to the best of the Provider’s knowledge and belief that: (i) no federal appropriated funds have been paid or will be paid, by or on behalf of Provider, to any person for influencing or attempting to influence an officer or employee of an agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment or modification of any federal contract, grant, loan or cooperative agreement; (ii) if any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with this federal contract, grant, loan or cooperative agreement, Provider will complete and submit Standard Form LLL, “Disclosure Form to Report Lobbying” in accordance with its instructions; (iii) Provider will 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; (iv) this certification is a material representation of fact upon which reliance was placed when this Agreement and the OHP Contract was made or entered into. Submission of this certification is a prerequisite for making or entering into this

Agreement imposed by Section 1352, Title 31, of the U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

32. **HIPAA.** The parties acknowledge and agree that each of OHA, Health Share, and the Provider is a “covered entity” for purposes of privacy and security provisions of the Health Insurance Portability and Accountability Act and the federal regulations implementing the Act (collectively referred to as HIPAA). Provider will comply with HIPAA to the extent that any obligations arising under the Agreement are covered by HIPAA. Provider will develop and implement such policies and procedures for maintaining the privacy and security of records and authorizing the use and disclosure of records required to comply with this Agreement and the OHP Contract and with HIPAA. Provider will comply with HIPAA and the following: (i) Individually Identifiable Health Information about specific individuals is protected from unauthorized use or disclosure consistent with the requirements of HIPAA. Provider will not use or disclose any Individually Identifiable Health Information about specific individuals in a manner that would violate HIPAA, Privacy Rules in 45 CFR Parts 160 and 164, OHA Privacy Rules, OAR 407-014-0000 et. seq., or either the OHA or Health Share 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/Forms/Served/DE2090.pdf>, or may be obtained from OHA. A copy of Health Share’s Notice of Privacy Practices is posted on the web site at: <http://healthshareoregon.org/notice-of-privacy-practice/>; (ii) Provider will adopt and employ reasonable administrative and physical safeguards consistent with the Security Rules in 45 CFR Part 164 to ensure that Member Information shall be used by or disclosed only to the extent necessary for the permitted use or disclosure and consistent with applicable State and federal laws and the terms and conditions of this Contract. Security incidents involving Member Information must be immediately reported to Health Share’s Privacy Officer; (iii) Provider will comply with the HIPAA standards for electronic transactions published in 45 CFR Part 162 and the DHS EDT Rules, OAR 410-001-0000 through 410-001-0200. In order for Provider to exchange electronic data transactions with OHA in connection with Claims or encounter data, eligibility or Enrollment information, authorizations or other electronic transaction, Contractor shall execute an EDT Trading Partner Agreement with OHA and shall comply with the OHA EDT Rules; and (iv) If Provider 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, Provider will promptly consult the Health Share HIPAA officer. Provider, Health Share, or OHA may initiate a request for testing of HIPAA transaction requirements, subject to available resources and OHA testing schedule.
33. **Resource Conservation and Recovery.** Provider will comply with all mandatory standards and policies that relate to resource conservation and recovery pursuant to the Resource Conservation and Recovery Act (codified at 42 USC 6901 et seq.). Section 6002 of that Act (codified at 42 USC 6962) requires that preference be given in procurement programs to the purchase of specific products containing recycled materials identified in guidelines developed by the Environmental Protection Agency. Current guidelines are set forth in 40 CFR Part 247.

34. **Audits.** Provider will 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."
35. **Debarment and Suspension.** Provider represents and warrants that it is not, and that none of Provider's employees, contractors, service providers, personnel or workforce members is not, listed on the non-procurement portion of the General Service Administration's "List of Parties Excluded from Federal Procurement or Nonprocurement Programs" in accordance with Executive Orders No. 12549 and No. 12689, "Debarment and Suspension." (See 2 CFR Part 180.) This list contains the names of parties debarred, suspended, or otherwise excluded by agencies, and contractors declared ineligible under statutory authority other than Executive Order No. 12549.
36. **Drug-Free Workplace.** Provider will comply with the following provisions to maintain a drug-free workplace: (i) Provider 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 Provider's workplace or while providing services to Clients. Provider's notice will specify the actions that will be taken by Provider against its employees for violation of such prohibitions; (ii) Establish a drug-free awareness program to inform its employees about: The dangers of drug abuse in the workplace, Provider's policy of maintaining a drug-free workplace, any available drug counseling, rehabilitation, and employee assistance programs, and the penalties that may be imposed upon employees for drug abuse violations; (iii) Provide each employee to be engaged in the performance of services under this Agreement a copy of the statement mentioned in Paragraph (i) above; (iv) Notify each employee in the statement required by Paragraph (i) above, that, as a condition of employment to provide services under this Agreement, the employee will: abide by the terms of the statement, and notify the employer of any criminal drug statute conviction for a violation occurring in the workplace no later than five days after such conviction; (v) Notify Health Share within 10 days after receiving notice under Paragraph (iv) above, from an employee or otherwise receiving actual notice of such conviction; (vi) Impose a sanction on, or require the satisfactory participation in a drug abuse assistance or rehabilitation program by any employee who is so convicted as required by Section 5154 of the Drug-Free Workplace Act of 1988; (vii) Make a good-faith effort to continue a drug-free workplace through implementation of Paragraphs (i) through (vi) above; (viii) Require any Subcontractor to comply with Paragraphs (i) through (vii) above; (ix) Neither Provider, or any of Provider's employees, officers, agents or Subcontractors may provide any service required under this Agreement while under the influence of drugs. For purposes of this provision, "under the influence" means: observed abnormal behavior or impairments in mental or physical performance leading a reasonable person to believe the Provider or Provider's employee, officer, agent or Subcontractor has used a controlled substance, prescription or non-prescription medication that impairs the Provider or Provider's employee, officer, agent or Subcontractor's performance of essential job function or creates a direct threat to Clients or others. Examples of abnormal behavior include, but are not limited to: hallucinations, paranoia or violent outbursts. Examples of impairments in physical or mental performance include, but are not limited to: slurred

speech, difficulty walking or performing job activities; and (x) Violation of any provision of this subsection may result in termination of this Agreement.

37. **Pro-Children Act.** Provider will comply with the Pro-Children Act of 1994 (codified at 20 USC §6081 et seq.).
38. **Additional Medicaid and CHIP Requirements.** Provider will comply with all applicable federal and State laws and regulations pertaining to the provision of OHP Services under the Medicaid Act, Title XIX, 42 USC §1396 et seq., and CHIP benefits established by Title XXI of the Social Security Act, including without limitation the following: (i) Keep such records as are necessary to fully disclose the extent of the services provided to individuals receiving OHP assistance and shall furnish such information to any State or federal agency responsible for administering the OHP program regarding any payments claimed by such person or institution for providing OHP Services as the State or federal agency may from time to time request. 42 USC §1396a(a)(27); 42 CFR 431.107(b)(1) & (2); and 42 CFR 457.950(a)(3). (ii) Comply with all disclosure requirements of 42 CFR 1002.3(a); 42 CFR 455 Subpart (B); and 42 CFR 457.900(a)(2). (iii) Maintain written notices and procedures respecting Advance Directives in compliance with 42 USC Section 1396(a)(57) and (w), 42 CFR 431.107(b)(4), and 42 CFR 489 Subpart I. (iv) Certify when submitting any Claim for the provision of OHP Services that the information submitted is true, accurate and complete. Provider will acknowledge Provider's understanding that payment of the Claim will be from federal and State funds and that any falsification or concealment of a material fact may be prosecuted under federal and State laws. (v) Entities receiving \$5 million or more annually (under this Contract and any other OHP contract) for furnishing Medicaid health care items or services shall, as a condition of receiving such payments, adopt written fraud, waste and Abuse policies and procedures and inform employees, contractors and agents about the policies and procedures in compliance with Section 6032 of the Deficit Reduction Act of 2005, 42 USC § 1396a(a)(68).
39. **Agency-based Voter Registration.** If applicable, Provider will comply with the Agency-based Voter Registration sections of the National Voter Registration Act of 1993 that require voter registration opportunities be offered where an individual may apply for or receive an application for public assistance.
40. **Clinical Laboratory Improvements.** Provider will ensure that any Laboratories use by Provider shall comply with the Clinical Laboratory Improvement Amendments (CLIA 1988), 42 CFR Part 493 Laboratory Requirements and ORS 438 (Clinical Laboratories, which require that all laboratory testing sites providing services under the OHP Contract shall have either a Clinical Laboratory Improvement Amendments ("CLIA") certificate of waiver or a certificate of registration along with a CLIA identification number. Those Laboratories with certificates of waiver will provide only the eight types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.
41. **Advance Directives.** Provider will comply with 42 CFR Part 422.128 for maintaining written policies and procedures for Advance Directives. This includes compliance with 42 CFR 489, Subpart I "Advance Directives" and OAR 410-120-1380, which establishes, among other requirements the requirements for compliance with Section 4751 of the

Omnibus Budget Reconciliation Act of 1991 (“OBRA”) and ORS 127.649, Patient Self-Determination Act. Provider will maintain written policies and procedures concerning Advance Directives with respect to all adult Members receiving medical care by Provider. Provider will provide adult Members with written information on Advance Directive policies and include a description of Oregon law. The written information provided by Provider must reflect changes in Oregon law as soon as possible, but no later than 90 days after the effective date of any change to Oregon law. Provider must also provide written information to adult Members with respect to the following: (i) Their rights under Oregon law; and (ii) Provider’s policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of Advance Directives as a matter of conscience. (iii) Provider must inform Members that complaints concerning noncompliance with the Advance Directive requirements may be filed with OHA.

42. **Office of Minority, Women and Emerging Small Businesses.** If Provider lets any subcontracts, Provider will take affirmative steps to: include qualified small and minority and women’s businesses on solicitation lists, assure that small and minority and women’s businesses are solicited whenever they are potential sources, divide total requirements into smaller tasks or quantities when economically feasible so as to permit maximum small and minority and women’s business participation, establish delivery schedules when requirements permit which will encourage participation by small and minority and women’s businesses, and use the services and assistance of the Small Business Administration, the Office of Minority Business Enterprise of the Department of Commerce and the Community Services Administration as required.
43. **Practitioner Incentive Plans (“PIP”).** Provider may operate a Practitioner Incentive Plan only if no specific payment is made directly or indirectly under the plan to a Provider as inducement to reduce or limit Medically Appropriate Covered Services provided to a Member. Contractor shall comply with all requirements of Exhibit H of the OHP Contract, Practitioner Incentive Plan Regulation Guidance, to ensure compliance with Sections 4204(a) and 4731 of the Omnibus Budget Reconciliation Act of 1990 that concern Practitioner Incentive Plans.
44. **Conflict of Interest Safeguards.** Provider will not recruit, promise future employment, or hire any DHS or OHA employee (or their relative or member of their household) who has participated personally and substantially in the procurement or administration of the OHP Contract as a DHS or OHA employee. Provider will not offer to any DHS or OHA employee (or any relative or member of their household) any gift or gifts with an aggregate value in excess of \$50 during a calendar year or any gift or payment of expenses for entertainment. “Gift” for this purpose has the meaning defined in ORS 244.020(6) and OAR 199-005-0001 to 199-005-0035. Provider will not retain a former DHS or OHA employee to make any communication with or appearance before OHA on behalf of Health Share in connection with the OHP Contract if that person participated personally and substantially in the procurement or administration of the OHP Contract as a DHS or OHA employee. If a former DHS or OHA employee authorized or had a significant role in the OHP Contract, Provider will not hire such a person in a position having a direct, beneficial, financial interest in the OHP Contract during the two year period following that person’s termination from DHS or OHA. Provider will develop

appropriate policies and procedures to avoid actual or potential conflict of interest involving Members, DHS or OHA employees, and sub-contractors.

45. **Non-Discrimination.** Provider will comply with all federal and State laws and regulations including Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972 (regarding education programs and activities) the Age Discrimination Act of 1975, the Rehabilitation Act of 1973, the Americans with Disabilities Act (“ADA”) of 1990, and all amendments to those acts and all regulations promulgated thereunder. Provider will also comply with all applicable requirements of State civil rights and rehabilitation statutes and rules. Provider will comply with, the integration mandate in 28 CFR 35.130(d), Title II of the Americans with Disabilities Act and its implementing regulations published in the Code of Federal Regulations.
46. **Electronic Data Systems.** To the extent applicable, Provider will comply with the Outcome and Assessment Information Set (“OASIS”) reporting requirements and patient notice requirements for skilled services provided by Home Health Agencies, pursuant to CMS requirements published in 64 FR 3764, 64 FR 3748, 64 FR 23846, and 64 FR 32984, and such subsequent regulations as CMS may issue in relation to the OASIS program. Provider will also comply, as applicable, with the requirements of the Oregon Addictions and Mental Health (AMH) Division’s electronic data system to include OWITS Behavioral Electronic Health Records, enhanced data capture through OWITS EHR, Electronic Data Interchange/Transfer from existing EHR or the MOTS Client Data Entry, and the AMH Contracts and Payments System.
47. **Patient Rights Condition of Participation.** To the extent applicable, Provider will comply with, the Patient Rights Condition of Participation (“COP”) that hospitals must meet to continue participation in the Medicaid program, pursuant to 42 CFR Part 482. For purposes of this Contract, hospitals include short-term, psychiatric, rehabilitation, long-term, and children’s hospitals.
48. **Federal Grant Requirements.** The federal Medicaid rules establish that OHA is a recipient of federal financial assistance, and therefore is subject to federal grant requirements pursuant to 42 CFR 430.2(b). To the extent applicable to Provider or to the extent OHA requires Provider to supply information or comply with procedures to permit OHA to satisfy its obligations federal grant obligations or both, Provider must comply with the following parts of 45 CFR: (i) Part 74, including Appendix A (uniform federal grant administration requirements); (ii) Part 80 (nondiscrimination under Title VI of the Civil Rights Act); (iii) Part 84 (nondiscrimination on the basis of handicap); (iv) Part 91 (nondiscrimination on the basis of age); (v) Part 95 (Medicaid and CHIP federal grant administration requirements); and (vi) Provider will not expend any of the funds paid under this Contract for roads, bridges, stadiums, or any other item or service not covered under the OHP.
49. **Workers’ Compensation Coverage.** Provider will comply with ORS 656.017, and will provide worker’s compensation insurance coverage for those workers, unless they meet the requirement for an exemption under ORS 656.126(2).
50. **Conflicts.** Conflicts between the main body of the Agreement and this OHP Addendum will be resolved and controlled by this OHP Addendum.

COVERED SERVICES AND COMPENSATION ADDENDUM
Outpatient Mental Health Services (Case Rate)
Adult and Youth

A. SERVICE DESCRIPTION

1. Outpatient mental health services means a publicly or privately operated program as defined in OAR 309-019-0105 (65) that include a combination of time-limited assessment; individual, family and group therapy; medication management; case management; skills training and/or service coordination for individuals with social, emotional, and/or mental health conditions that impair daily functioning.
2. Outpatient mental health services are designed to quickly promote or restore an individual's previous level of high function/stability, or maintain social/emotional functioning. Outpatient mental health services are intended to be focused and time-limited and a Member is transitioned once the Member is able to function and maintain their social, emotional and/or mental health without ongoing recovery support services. Services and activities are to be provided in a trauma informed and culturally appropriate manner. Services provided to the Member may include services that are delivered in the community or in-home as mutually agreed on by Provider and Member.
3. Provider shall provide those outpatient mental health services to Members for which it is licensed and certified to provide. Provider shall not refuse to provide services to any Member who is clinically appropriate for services.
4. Provider shall provide the following outpatient mental health services to Members:

Child/Youth	Adult
<input checked="" type="checkbox"/> Level A	<input checked="" type="checkbox"/> Level A
<input checked="" type="checkbox"/> Level B	<input checked="" type="checkbox"/> Level A MRDD
<input checked="" type="checkbox"/> Level C	<input checked="" type="checkbox"/> Level B
<input type="checkbox"/> Level D HBS	<input checked="" type="checkbox"/> Level B SPMI
	<input checked="" type="checkbox"/> Level C
	<input checked="" type="checkbox"/> Level C SPMI
	<input type="checkbox"/> Level D TAY
	<input type="checkbox"/> Level D ICM

5. Provider shall comply with OAR 309-019-0100 through 309-019-0220 regarding minimum standards for services and supports provided by addictions and mental health providers, as applicable. Provider must be certified to provide mental health

services to Members under OAR 309-012-0130 through 309-012-0230 if delivering services with unlicensed personnel.

6. Provider shall comply with ORS 182.515 and 182.525, Evidence-Based Programs.
7. Provider agrees to provide services in accordance with the Provider Manual in effect at the time services are rendered. Provider shall further ensure that all clinical staff are trained on the use of that manual.
8. Provider shall maintain required access for routine, urgent and emergent appointments within timelines per the access requirements outlined in Regional Access Report included in the Provider Manual.
9. Provider shall ensure follow-up care for Members after discharge from a hospital for mental illness within seven (7) days of hospital discharge.
10. Provider shall assign Levels of Care (LOC) accurately and with inter-rater reliability.
11. Provider shall ensure Members are receiving the frequency and intensity of service that is clinically indicated by the consumer's LOC.
12. Provider shall improve outcomes by the use of approved outcomes tools located in the Provider Manual.
13. Provider shall provide 24-hour, seven day a week telephonic or face-to-face crisis support coverage as outlined in OAR Chapter 309.

B. COMPENSATION AND PAYMENT

1. Health Share shall reimburse Provider a case rate, as described in the Regional Rate Guide which is included as part of the Provider Manual.
2. Case rates will be paid in full at point of first valid encounter only. Any changes to the case rates must be negotiated with Health Share.
3. Health Share will implement a risk corridor which adjusts payments based on the fee-for-service equivalent value of encountered services. At which time the risk corridor is developed and implemented, the methodology for calculating the risk corridor and determining payment adjustments will be included in the Provider Manual.
4. Claims may be submitted in either paper or electronic format. Provider understands and agrees that all billing for services provided by Provider pertaining to this Agreement shall be billed to Health Share's Third Party Administrator, Performance Health Technology (PH Tech), consistent with the Provider Manual and in accordance with OAR 410-141-3420. Further, Provider understands and agrees that

the BH RAE to which a Member is assigned shall be responsible for authorizing services through PH Tech.

COVERED SERVICES AND COMPENSATION ADDENDUM
Substance Use Disorder Outpatient Services
Adult and Youth

A. SERVICE DESCRIPTION

1. Substance Use Disorder (SUD) Outpatient Services means a publicly or privately operated program as defined in ORS 430.010 and OAR 309-019-0100 and generally provide professionally-directed screening, evaluation, treatment, and ongoing recovery and disease management services for Members with substance use disorders.
2. SUD Outpatient Services therapies involve skilled treatment services, which may include individual and group counseling, motivational enhancement, family therapy, educational groups, occupational and recreational therapy, psychotherapy, addiction pharmacotherapy, or other therapies.
3. Provider shall provide Substance Use Disorder Outpatient Services to Members, pursuant to ASAM Levels 1.0 and 2.1 and Provider's license and certification. Provider shall not refuse to provide services to any Member who is clinically appropriate for services. Provider must provide services in a trauma informed and culturally appropriate manner.
4. Provider shall comply with OAR 309-019-0100 through 309-019-0220 regarding minimum standards for services and supports provided by addictions and mental health providers, as applicable. Provider must also have a current license issued by OHA in accordance with OAR 415-012-000 through 415-012-0090.
5. Provider shall comply with ORS 182.515 and 182.525, Evidence-Based Programs.
6. Provider agrees to provide services in accordance with the Provider Manual in effect at the time services are rendered. Provider shall further ensure that all clinical staff are trained on the use of that manual.

B. COMPENSATION AND PAYMENT

1. Health Share shall reimburse Provider at a Fee for Service rate per the Regional Rate Guide which is included as part of the Provider Manual.
2. Claims may be submitted in either paper or electronic format. Provider understands and agrees that all billing for services provided by Provider pertaining to this

Agreement shall be billed to Health Share's Third Party Administrator, Performance Health Technology (PH Tech), consistent with the Provider Manual and in accordance with OAR 410-141-3420. Further, Provider understands and agrees that the BH RAE to which a Member is assigned shall be responsible for authorizing services through PH Tech.

COVERED SERVICES AND COMPENSATION ADDENDUM
Psychological Testing

A. SERVICE DESCRIPTION

1. Psychological testing means administering, scoring, and interpreting tests of mental abilities or personality in order to assist in the assessment or diagnosis of mental disorders or mental functioning, as defined in OAR 858-010-0001(1)(a).
2. Psychological testing consists of face-to-face psychological assessment of a Member and includes the following: clinical interview with member and collateral sources, integration of collateral information, including previous psychological or neuropsychological testing and history and background information. Tests administered must directly address referral question, must primarily include tests beyond self-report measures, and include psycho-diagnostic assessment of emotionality, intellectual abilities, personality and psychopathology.
3. Provider shall ensure that psychological testing is provided by a licensed professional who is adequately trained to administer and score the specific test being used and maintain standards for the testing environment and testing administration as set forth in the most recent editions of the American Psychological Association Standards for Educational and Psychological Tests and Ethical Principles for Psychologists.
4. Provider shall provide those psychological testing services to Members which it is licensed and certified to provide. Provider shall not refuse to provide services to any Member who is clinically appropriate for services. Services must be pre-authorized. Services are to be provided in a trauma-informed and culturally appropriate manner.
5. Provider must comply with OAR 858-010-0010 through 858-010-0080.
6. Provider shall comply with ORS 182.515 and 182.525, Evidence-Based Programs.
7. Provider agrees to provide services in accordance with the Provider Manual in effect at the time services are rendered. Provider shall further ensure that all clinical staff are trained on the use of that manual.

B. COMPENSATION AND PAYMENT

1. Health Share shall reimburse Provider at a Fee for Service rate for codes 96101 and 90791, per the Regional Rate Guide which is included as part of the Provider Manual. Authorization Requests will pend for BH RAE approval.

2. Claims may be submitted in either paper or electronic format. Provider understands and agrees that all billing for services provided by Provider pertaining to this Agreement shall be billed to Health Share's Third Party Administrator, Performance Health Technology (PH Tech), consistent with the Provider Manual and in accordance with OAR 410-141-3420. Further, Provider understands and agrees that the BH RAE to which a Member is assigned shall be responsible for authorizing services through PH Tech.