Health, Housing & Human Services
CLACKAMAS COUNTY

Mary Rumbaugh
Director

October 2, 2025 BCC Agenda Date/Item: _____

Board of County Commissioners
Clackamas County

Approval of a Revenue Provider Agreement with Health Net Plan of Oregon for reimbursement of services provided to the Plan's Members. Agreement Value is $300,000 for 15 years. Funding is through Health Net Plan of Oregon. No County General Funds are involved.

Previous Board Action/Review	Briefed at Issues – September 30, 2025		
Performance Clackamas	Healthy People		
Counsel Review	Yes: Sarah Foreman	**Procurement Review**	No
Contact Person	Sarah Jacobson	**Contact Phone**	503-742-5303

EXECUTIVE SUMMARY: The Health Centers Division of Health, Housing, and Human Services Department requests approval of a Provider Agreement with Health Net Plan of Oregon, Inc., Trillium Community Health Plan. The purpose of this agreement is to bill Health Net Plan of Oregon, Inc. for reimbursement of services provided to their members at the Health Centers' clinics. This agreement is estimated to provide $20,000 in revenue annually for an estimated total contract value of $300,000. In fiscal year 2024-2025, the Health Centers Division's clinics served 343 Health Net Plan members. The services provided to Health Net Plan members encompass behavioral health and primary care.

RECOMMENDATION: The staff respectfully requests that the Board of County Commissioners approve this Provider Agreement (#10339) with Health Net Plan of Oregon, Inc., and authorize Chair Roberts or his designee to sign on behalf of Clackamas County.

Respectfully submitted,

Mary Rumbaugh

Mary Rumbaugh
Director of Health, Housing, and Human Services

For Filing Use Only

PARTICIPATING PROVIDER AGREEMENT

This Participating Provider Agreement (together with all Attachments and amendments, this "***Agreement***") is made and entered by and between County of Clackamas, Oregon ("***Provider***") and Health Net Health Plan of Oregon, Inc. ("***Health Plan***") (each a "***Party***" and collectively the "***Parties***"). This Agreement is effective as of the date designated by Health Plan on the signature page of this Agreement ("***Effective Date***").

WHEREAS, Provider desires to provide certain health care services to individuals in products offered by or available from or through a Company or Payor (as hereafter defined), and Provider desires to participate in such products as a Participating Provider (as defined herein), all as hereinafter set forth.

WHEREAS, Health Plan desires for Provider to provide such health care services to individuals in such products, and Health Plan desires to have Provider participate in certain of such products as a Participating Provider, all as hereinafter set forth.

NOW, THEREFORE, in consideration of the recitals and mutual promises herein stated, the Parties hereby agree to the provisions set forth below.

ARTICLE I - DEFINITIONS

When appearing with initial capital letters in this Agreement (including an Attachment(s)), the following quoted and underlined terms (and the plural thereof, when appropriate) have the meanings set forth below.

1.1. "Affiliate" means a person or entity directly or indirectly controlling, controlled by, or under common control with Health Plan, including, but not limited to, Trillium Community Health Plan, Inc. and Health Net Life Insurance Company.

1.2. "Attachment" means any document, including an addendum, schedule or exhibit, attached to this Agreement as of the Effective Date or that becomes attached pursuant to Section 2.2 or Section 8.7, all of which are incorporated herein by reference and may be amended from time to time as provided in this Agreement.

1.3. "Clean Claim" has, as to each particular Product, the meaning set forth in the applicable Product Attachment or, if no such definition exists, the Provider Manual.

1.4. "Company" means (collectively or individually, as appropriate in the context) Health Plan and/or one or more of its Affiliates, except those specifically excluded by Health Plan.

1.5. "Compensation Schedule" means at any given time the then effective schedule(s) of maximum rates applicable to a particular Product under which Provider and Contracted Providers will be compensated for the provision of Covered Services to Covered Persons. Such Compensation Schedule(s) will be set forth or described in one or more Attachments to this Agreement, and may be included within a Product Attachment.

1.6. "Contracted Provider" means a physician, hospital, health care professional or any other provider of items or services that is employed by or has a contractual relationship with Provider and that provides Covered Services. The term "Contracted Provider" includes Provider for those Covered Services provided by Provider.

1.7. "Coverage Agreement" means any agreement, program or certificate entered into, issued or agreed to by Company or Payor, under which Company or Payor furnishes administrative services or other services in support of a health care program for an individual or group of individuals, and which may include access to one or more of Company's provider networks or vendor arrangements, except those excluded by Health Plan.

1.8. "Covered Person" means any individual entitled to receive Covered Services pursuant to the terms of a Coverage Agreement. Covered Person may also be referred to in certain Coverage Agreements as "Member" or "Beneficiary".

1.9. "Covered Services" means those services and items for which benefits are available and payable under the applicable Coverage Agreement and which are determined, if applicable, to be Medically Necessary under the applicable Coverage Agreement.

1.10. "Medically Necessary" or "Medical Necessity" shall have the meaning defined in the applicable Coverage Agreement or applicable Regulatory Requirements.

1.11. "Participating Provider" means, with respect to a particular Product, any physician, hospital, ancillary, or other health care provider that has contracted, directly or indirectly, with Health Plan to provide Covered Services to Covered Persons, that has been approved for participation by Company, and that is designated by Company as a "participating provider" in such Product.

1.12. "Payor" means the entity (including Company where applicable) that bears direct financial responsibility for paying from its own funds, without reimbursement from another entity, the cost of Covered Services rendered to Covered Persons under a Coverage Agreement and, if such entity is not Company, such entity contracts, directly or indirectly, with Company for the provision of certain administrative or other services with respect to such Coverage Agreement.

1.13. "Payor Contract" means the contract with a Payor, pursuant to which Company furnishes administrative services or other services in support of the Coverage Agreements entered into, issued or agreed to by a Payor, which services may include access to one or more of Company's provider networks or vendor arrangements, except those excluded by Health Plan. The term "Payor Contract" includes Company's or other Payor's contract with a governmental authority (also referred to herein as a "Governmental Contract") under which Company or Payor arranges for the provision of Covered Services to Covered Persons.

1.14. "Product" means any program or health benefit arrangement designated as a "product" by Health Plan (e.g., Health Plan Product, Medicaid Product, PPO Product, Payor-specific Product, etc.) that is now or hereafter offered by or available from or through Company (and includes the Coverage Agreements that access, or are issued or entered into in connection with such product, except those excluded by Health Plan).

1.15. "Product Attachment" means an Attachment setting forth requirements, terms and conditions specific or applicable to one or more Products, including certain provisions that must be included in a provider agreement under the Regulatory Requirements, which may be alternatives to, or in addition to, the requirements, terms and conditions set forth in this Agreement or the Provider Manual.

1.16. "Provider Manual" means the provider manual and any billing manuals, adopted by Company or Payor which include, without limitation, requirements relating to utilization management, quality management, grievances and appeals, and Product-specific, Payor-specific and State-specific requirements, as may be amended from time to time by Company or Payor.

1.17. "Regulatory Requirements" means all applicable federal and state statutes, regulations, regulatory guidance, judicial or administrative rulings, requirements of Governmental Contracts and standards and requirements of any accrediting or certifying organization, including, but not limited to, the requirements set forth in a Product Attachment.

1.18. "State" is defined as the state identified in the applicable Attachment.

ARTICLE II - PRODUCTS AND SERVICES

2.1. Contracted Providers. Provider shall, and shall cause each Contracted Provider, to comply with and abide by the agreements, representations, warranties, acknowledgements, certifications, terms and conditions of this Agreement (including the provisions of Schedule A that are applicable to Provider, a Contracted Provider, or their services, and any other Attachments), and the Provider Manual, and fulfill all of the duties, responsibilities and

obligations imposed on Provider and Contracted Providers under this Agreement (including each Attachment), and the Provider Manual.

2.2. Participation in Products. Subject to the other provisions of this Agreement, each Contracted Provider may be identified as a Participating Provider in each Product identified in a Product Attachment designated on Schedule B of this Agreement or added to this Agreement in accordance with Section 2.2 hereof.

2.2.1. Provider shall, at all times during the term of this Agreement, require each of its Contracted Providers to, subject to Company's approval, participate as Participating Providers in each Product identified in a Product Attachment that is designated on Schedule B to this Agreement or added to this Agreement in accordance with Section 2.2 hereof.

2.2.2. A Contracted Provider may only identify itself as a Participating Provider for those Products in which the Contracted Provider actually participates as provided in this Agreement. Provider acknowledges that Company or Payor may have, develop or contract to develop various Products or provider networks that have a variety of provider panels, program components and other requirements. No Company or Payor warrants or guarantees that any Contracted Provider: (i) will participate in all or a minimum number of provider panels, (ii) will be utilized by a minimum number of Covered Persons, or (iii) will indefinitely remain a Participating Provider or member of the provider panel for a particular network or Product.

2.2.3. Provider shall provide Health Plan with the information listed on Schedule C entitled "Information for Contracted Providers" for itself and the Contracted Providers as of the Effective Date. Provider shall provide Health Plan, from time to time or on a periodic basis as requested by Health Plan, with a complete and accurate list of Information for Contracted Providers and such other information as mutually agreed upon by the Parties, and shall provide Health Plan with a list of modifications to such list at least 30 days prior to the effective date of such changes, when possible. Provider shall provide such lists in a manner and format mutually acceptable to the Parties.

2.2.4. Provider may add new providers to this Agreement as Contracted Providers. In such case, Provider shall provide written notice to Health Plan of the prospective addition(s), and shall use best efforts to provide such notice at least sixty (60) days in advance of such addition. Provider shall maintain policies and procedures for each of its employed Contracted Providers and written agreements with each of its subcontracted Contracted Providers (other than Provider) that require the Contracted Providers to comply with Regulatory Requirements and the terms and conditions of this Agreement that apply to Contracted Providers.

2.2.5. If Company desires to add one or more Contracted Providers to an additional Product, Company or Payor, as applicable, will provide advance written notice (electronic or paper) thereof to Provider, along with the applicable Product Attachment and the new Compensation Schedule, if any. The applicable Contracted Providers will not be designated as Participating Providers in such additional Product if Provider opts out of such additional Product by giving Company or Payor, as applicable, written notice of its decision to opt-out within 30 days of Company's or Payor's, as applicable, giving of written notice. If Provider timely provides such opt-out notice, the applicable Contracted Providers will not be considered Participating Providers in such Product. If Provider does not timely provide such opt-out notice, then each applicable Contracted Provider shall be a Participating Provider in such additional Product on the terms and conditions set forth in this Agreement and the applicable Product Attachment.

2.3. Covered Services. Each Contracted Provider shall provide Covered Services described or referenced in the applicable Product Attachment(s) to Covered Persons in those Products in which the Contracted Provider is a Participating Provider, in accordance with this Agreement. Each Contracted Provider shall provide Covered Services to Covered Persons with the same degree of care and skill as customarily provided to patients who are not Covered Persons, within the scope of the Contracted Provider's license and in accordance with generally accepted standards of the Contracted Provider's practice and business and in accordance with the provisions of this Agreement, the Provider Manual, and Regulatory Requirements.

2.4. Provider Manual; Policies and Procedures. Provider and Contracted Providers shall at all times cooperate and comply with the requirements, policies, programs and procedures ("Policies") of Company and Payor, which may be described in the Provider Manual and include, but are not limited to, the following: credentialing criteria and requirements; notification requirements; medical management programs; claims and billing, quality assessment and improvement, utilization review and management, disease management, case management, on-site reviews, referral and prior authorization, and grievance and appeal procedures; coordination of benefits and third party liability policies; carve-out and third party vendor programs; and data reporting requirements. The failure to comply with such Policies could result in a denial or reduction of payment to the Provider or Contracted Provider or a denial or reduction of the Covered Person's benefits. Such Policies do not in any way affect or remove the obligation of Contracted Providers to render care. Health Plan shall make the Provider Manual available to Provider and Contracted Providers via one or more designated websites or alternative means. Upon Provider's reasonable request, Health Plan shall provide Provider with a copy of the Provider Manual. In the event of a material change to the Provider Manual, Health Plan will use reasonable efforts to notify Provider in advance of such change. Such notice may be given by Health Plan through a periodic provider newsletter, an update to the on-line Provider Manual, or any other written method (electronic or paper).

2.5. Credentialing Criteria. Provider and each Contracted Provider shall complete Company's and/or Payor's credentialing and/or recredentialing process as required by Company's and/or Payor's credentialing Policies, and shall at all times during the term of this Agreement meet all of Company's and/or Payor's credentialing criteria. Provider and each Contracted Provider represents, warrants and agrees: (a) that it is currently, and for the duration of this Agreement shall remain: (i) in compliance with all applicable Regulatory Requirements, including licensing laws; (ii) if applicable, accredited by The Joint Commission or the American Osteopathic Association; and (iii) a Medicare participating provider under the federal Medicare program and a Medicaid participating provider under applicable federal and State laws; and (b) that all Contracted Providers and all employees and contractors thereof will perform their duties in accordance with all Regulatory Requirements, as well as applicable national, State and local standards of professional ethics and practice. No Contracted Provider shall provide Covered Services to Covered Persons or identify itself as a Participating Provider unless and until the Contracted Provider has been notified, in writing, by Company that such Contracted Provider has successfully completed Company's credentialing process.

2.6. Eligibility Determinations. Provider or Contracted Provider shall timely verify whether an individual seeking Covered Services is a Covered Person. Company or Payor, as applicable, will make available to Provider and Contracted Providers a method, whereby Provider and Contracted Providers can obtain, in a timely manner, general information about eligibility and coverage. Company or Payor, as applicable, does not guarantee that persons identified as Covered Persons are eligible for benefits or that all services or supplies are Covered Services. If Company, Payor or its delegate determines that an individual was not a Covered Person at the time services were rendered, such services shall not be eligible for payment under this Agreement. In addition, Company will use reasonable efforts to include or contractually require Payors to clearly display Company's name, logo or mailing address (or other identifier(s) designated from time to time by Company) on each membership card.

2.7. Referral and Preauthorization Procedures. Provider and Contracted Providers shall comply with referral and preauthorization procedures adopted by Company and or Payor, as applicable, prior to referring a Covered Person to any individual, institutional or ancillary health care provider. Unless otherwise expressly authorized in writing by Company or Payor, Provider and Contracted Providers shall refer Covered Persons only to Participating Providers to provide the Covered Service for which the Covered Person is referred. Except as required by applicable law, failure of Provider and Contracted Providers to follow such procedures may result in denial of payment for unauthorized treatment.

2.8. Treatment Decisions. No Company or Payor is liable for, nor will it exercise control over, the manner or method by which a Contracted Provider provides items or services under this Agreement. Provider and Contracted Providers understand that determinations of Company or Payor that certain items or services are not Covered Services or have not been provided or billed in accordance with the requirements of this Agreement or the Provider Manual are administrative decisions only. Such decisions do not absolve the Contracted Provider of its responsibility to exercise independent judgment in treatment decisions relating to Covered Persons. Nothing in this Agreement (i) is intended to interfere with Contracted Provider's relationship with Covered Persons, or (ii) prohibits or restricts a

Contracted Provider from disclosing to any Covered Person any information that the Contracted Provider deems appropriate regarding health care quality, medical treatment decisions or alternatives.

2.9. Carve-Out Vendors. Provider acknowledges that Company may, during the term of this Agreement, carve-out certain Covered Services from its general provider contracts, including this Agreement, for one or more Products as Company deems necessary or appropriate. Provider and Contracted Providers shall cooperate with and, when medically appropriate, utilize all third party vendors designated by Company for those Covered Services identified by Company from time to time for a particular Product.

2.10. Disparagement Prohibition. Provider, each Contracted Provider and the officers of Company shall not disparage the other during the term of this Agreement or in connection with any expiration, termination or non-renewal of this Agreement. Neither Provider nor Contracted Provider shall interfere with Company's direct or indirect contractual relationships including, but not limited to, those with Covered Persons or other Participating Providers. Nothing in this Agreement should be construed as limiting the ability of either Health Plan, Company, Provider or a Contracted Provider to inform Covered Persons that this Agreement has been terminated or otherwise expired or, with respect to Provider, to promote Provider to the general public or to post information regarding other health plans consistent with Provider's usual procedures, provided that no such promotion or advertisement is specifically directed at one or more Covered Persons. In addition, nothing in this provision should be construed as limiting Company's ability to use and disclose information and data obtained from or about Provider or Contracted Provider, including this Agreement, to the extent determined reasonably necessary or appropriate by Company in connection with its efforts to comply with Regulatory Requirements and to communicate with regulatory authorities.

2.11. Nondiscrimination. Provider and each Contracted Provider will provide Covered Services to Covered Persons without discrimination on account of race, sex, sexual orientation, age, color, religion, marital status, national origin, place of residence, health status, type of Payor, source of payment (e.g., Medicaid generally or a State-specific health care program), physical or mental disability or veteran status, and will ensure that its facilities are accessible as required by Title III of the Americans With Disabilities Act of 1991. Provider and Contracted Providers recognize that, as a governmental contractor, Company or Payor may be subject to various State and federal laws, executive orders and regulations regarding equal opportunity and affirmative action, which also may be applicable to subcontractors, and Provider and each Contracted Provider agree to comply with such requirements as described in any applicable Attachment.

2.12. Notice of Certain Events. Provider shall give written notice to Health Plan of: (i) any event of which notice must be given to a licensing or accreditation agency or board; (ii) any change in the status of Provider's or a Contracted Provider's license; (iii) termination, suspension, exclusion or voluntary withdrawal of Provider or a Contracted Provider from any state or federal health care program, including but not limited to Medicaid; or (iv) any settlements or judgments in connection with a lawsuit or claim filed or asserted against Provider or a Contracted Provider alleging professional malpractice involving a Covered Person. In any instance described in subsection (i)-(iii) above, Provider must notify Health Plan or Payor in writing within 10 days, and in any instance described in subsection (iv) above, Provider must notify Health Plan or Payor in writing within 30 days, from the date it first obtains knowledge of the pending of the same.

2.13. Use of Name. Provider and each Contracted Provider hereby authorizes each Company or Payor to use their respective names, telephone numbers, addresses, specialties, certifications, hospital affiliations (if any), and other descriptive characteristics of their facilities, practices and services for the purpose of identifying the Contracted Providers as "Participating Providers" in the applicable Products. Provider and Contracted Providers may only use the name of the applicable Company or Payor for purposes of identifying the Products in which they participate, and may not use the registered trademark or service mark of Company or Payor without prior written consent.

2.14. Compliance with Regulatory Requirements. Provider, each Contracted Provider and Company agree to carry out their respective obligations under this Agreement and the Provider Manual in accordance with all applicable Regulatory Requirements, including, but not limited to, the requirements of the Health Insurance Portability and Accountability Act, as amended, and any regulations promulgated thereunder. If, due to Provider's or Contracted Provider's noncompliance with applicable Regulatory Requirements or this Agreement, sanctions or

penalties are imposed on Company, Company may, in its sole discretion, offset such amounts against any amounts due Provider or Contracted Providers from any Company or require Provider or the Contracted Provider to reimburse Company for such amounts.

2.15. Program Integrity Required Disclosures. Provider agrees to furnish to Health Plan complete and accurate information necessary to permit Company to comply with the collection of disclosures requirements specified in 42 C.F.R. Part 455 Subpart B or any other applicable State or federal requirements, within such time period as is necessary to permit Company to comply with such requirements. Such requirements include but are not limited to: (i) 42 C.F.R. §455.105, relating to (a) the ownership of any subcontractor with whom Provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request and (b) any significant business transaction between Provider and any wholly owned supplier or subcontractor during the 5 year period ending on the date of the request; (ii) 42 C.F.R. §455.104, relating to individuals or entities with an ownership or controlling interest in Provider; and (iii) 42 C.F.R. §455.106, relating to individuals with an ownership or controlling interest in Provider, or who are managing employees of Provider, who have been convicted of a crime.

ARTICLE III - CLAIMS SUBMISSION, PROCESSING, AND COMPENSATION

3.1. Claims or Encounter Data Submission. As provided in the Provider Manual and/or Policies, Contracted Providers shall submit to Payor or its delegate claims for payment for Covered Services rendered to Covered Persons. Contracted Provider shall submit encounter data to Payor or its delegate in a timely fashion, which must contain statistical and descriptive medical and patient data and identifying information, if and as required in the Provider Manual. Payor or its delegate reserves the right to deny payment to the Contracted Provider if the Contracted Provider fails to submit claims for payment or encounter data in accordance with the Provider Manual and/or Policies.

3.2. Compensation. The compensation for Covered Services provided to a Covered Person ("Compensation Amount") will be the appropriate amount under the applicable Compensation Schedule in effect on the date of service for the Product in which the Covered Person participates. Subject to the terms of this Agreement and the Provider Manual, Provider and Contracted Providers shall accept the Compensation Amount as payment in full for the provision of Covered Services. Subject to the terms of this Agreement, Payor shall pay or arrange for payment of each Clean Claim received from a Contracted Provider for Covered Services provided to a Covered Person in accordance with the applicable Compensation Amount less any applicable copayments, cost-sharing or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement.

3.3. Financial Incentives. The Parties acknowledge and agree that nothing in this Agreement shall be construed to create any financial incentive for Provider or a Contracted Provider to withhold Covered Services.

3.4. Hold Harmless. Provider and each Contracted Provider agree that in no event, including but not limited to non-payment by a Payor, a Payor's insolvency, or breach of this Agreement, shall Provider or a Contracted Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Covered Person or person acting on the Covered Person's behalf, other than Payor, for Covered Services provided under this Agreement. This provision shall not prohibit collection of any applicable copayments, cost-sharing or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement. This provision survives termination or expiration of this Agreement for any reason, will be construed for the benefit of Covered Persons, and supersedes any oral or written agreement entered into between Provider or a Contracted Provider and a Covered Person.

3.5. Recovery Rights. Payor or its delegate will provide written or electronic notice to Provider before using an offset of amounts owed by Provider or a Contracted Provider to Payor or Company against amounts owed by the Payor or Company to the Provider pr Contracted Provider as a means to recover an overpayment or payment made in error. Payor or its delegate will not implement the offset if, within 45 days after the date of the notice, Provider refunds the overpayment or payment made in error, or initiates an appeal. The notice shall explain the reason and calculation of the overpayment or payment made in error. Appeals shall be made pursuant to procedures set forth in the Policies and/or Provider Manual. Provider and Contracted Providers agree that all recoupment and any offset rights under this Agreement will constitute rights of recoupment authorized under State or federal law and that such

rights will not be subject to any requirement of prior or other approval from any court or other government authority that may now have or hereafter have jurisdiction over Provider or a Contracted Provider.

ARTICLE IV - RECORDS AND INSPECTIONS

4.1. Records. Each Contracted Provider shall maintain medical, financial and administrative records related to items or services provided to Covered Persons, including but not limited to a complete and accurate permanent medical record for each such Covered Person, in such form and detail as are required by applicable Regulatory Requirements and consistent with generally accepted medical standards.

4.2. Access. Provider and each Contracted Provider shall provide access to their respective books and records to each of the following, including any delegate or duly authorized agent thereof, subject to applicable Regulatory Requirements: (i) Company and Payor, during regular business hours and upon prior notice; (ii) appropriate State and federal authorities, to the extent such access is necessary to comply with Regulatory Requirements; and (iii) accreditation organizations. Provider and each Contracted Provider shall provide copies of such records at no expense to any of the foregoing that may make such request. Each Contracted Provider also shall obtain any authorization or consent that may be required from a Covered Person in order to release medical records and information to Company or Payor or any of their delegates. Provider and each Contracted Provider shall cooperate in and allow on-site inspections of its, his or her facilities and records by any Company, Payor, their delegates, any authorized government officials, and accreditation organizations. Provider and each Contracted Provider shall compile information necessary for the expeditious completion of such on-site inspection in a timely manner.

4.3. Record Transfer. Subject to applicable Regulatory Requirements, each Contracted Provider shall cooperate in the timely transfer of Covered Persons' medical records to any other health care provider, at no charge and when required.

ARTICLE V - INSURANCE AND INDEMNIFICATION

5.1. Insurance. During the term of this Agreement and for any applicable continuation period as set forth in Section 7.3 of this Agreement, Provider and/or each Contracted Provider shall maintain general and professional liability insurance and other insurance necessary to insure Provider and such Contracted Provider, respectively; their respective employees; and any other person providing services hereunder on behalf of Provider or such Contracted Provider, as applicable, against any claim(s) of personal injuries or death alleged to have been caused or caused by their performance under this Agreement. Such insurance shall provide coverage that is equivalent to "occurrence-based" coverage, or to "claims-based" coverage with a "tail" or prior acts coverage as necessary to avoid gaps in coverage. Insurance shall be through a self-funded insurance plan and/or a state-sponsored insurance pool (in lieu of purchasing coverage through a licensed carrier) in a minimum amount of $1,000,000 per occurrence, and $3,000,000 in the aggregate unless a lesser amount is accepted by Health Plan or where State law mandates otherwise. Provider and/or each Contracted Provider will provide Health Plan with at least 10 days prior written notice of cancellation, non-renewal, lapse, or adverse material modification of such coverage. Upon Health Plan's request, Provider and each Contracted Provider will furnish Health Plan with evidence of such insurance.

5.2. Indemnification by Provider and Contracted Provider. Subject to any applicable limits set forth in in the Oregon Constitution and the Oregon Tort Claims Act, Provider and each Contracted Provider shall indemnify and hold harmless (and at Health Plan's request defend) Company and Payor and all of their respective officers, directors, agents and employees from and against any and all third party claims for any loss, damages, liability, costs, or expenses (including reasonable attorney's fees) judgments or obligations arising from or relating to any negligence, wrongful act or omission, or breach of this Agreement by Provider, a Contracted Provider, or any of their respective officers, directors, agents or employees.

5.3. Indemnification by Health Plan. Health Plan agrees to indemnify and hold harmless (and at Provider's request defend) Provider, Contracted Providers, and their officers, directors, agents and employees from and against any and all third party claims for any loss, damages, liability, costs, or expenses (including reasonable

attorney's fees), judgments, or obligations arising from or relating to any negligence, wrongful act or omission or breach of this Agreement by Company or its directors, officers, agents or employees.

ARTICLE VI - DISPUTE RESOLUTION

6.1. Informal Dispute Resolution. Any dispute between Provider and/or a Contracted Provider, as applicable (the "Provider Party"), and Health Plan and/or Company, as applicable (including any Company acting as Payor) (the "Administrator Party"), with respect to or involving the performance under, termination of, or interpretation of this Agreement, or any other claim or cause of action hereunder, whether sounding in tort, contract or under statute (a "Dispute") shall first be addressed by exhausting the applicable procedures in the Provider Manual pertaining to claims payment, credentialing, utilization management, or other programs. If, at the conclusion of these applicable procedures, the matter is not resolved to satisfaction of the Provider Party and the Administrator Party, or if there are no applicable procedures in the Provider Manual, then the Provider Party and the Administrator Party shall engage in a period of good faith negotiations between their designated representatives who have authority to settle the Dispute, which negotiations may be initiated by either the Provider Party or the Administrator Party upon written request to the other, provided such request takes place within one year of the date on which the requesting party first had, or reasonably should have had, knowledge of the event(s) giving rise to the Dispute. If the matter has not been resolved within 60 days of such request, either the Provider Party or the Administrator Party may, as its sole and exclusive forum for the litigation of the Dispute or any part thereof, initiate arbitration pursuant to Section 6.2 below by providing written notice to the other party.

6.2. Arbitration If either the Provider Party or the Administrator Party wishes to pursue a Dispute as provided in Section 6.1, the party shall submit the Dispute to binding arbitration in accordance with the Commercial Arbitration Rules of the American Arbitration Association ("AAA"). The arbitration process must be initiated no later than 1 year following the end of the 60-day negotiation period set forth in Section 6.1, or the date of notice of termination, whichever occurs first. The arbitration will be conducted by an arbitrator chosen from the National Healthcare Panel, and the parties will mutually agree on a location in Clackamas County, Oregon. The arbitrator shall be neutral and without bias and must have expertise in Oregon healthcare law. The arbitrator shall not award punitive or exemplary damages and must adhere strictly to the terms of this Agreement and the laws of Oregon. The arbitrator will be bound by the controlling law and will apply Oregon law, unless otherwise expressly agreed to by the parties. Each party shall bear its own attorneys' fees and costs related to the arbitration except that: (1) AAA Administrative Fees, Arbitrator Compensation and any travel or additional expenses directly incurred by the arbitrator shall be equally split between the parties, unless otherwise specified by the arbitrator. The Provider Party shall not be required to pay more than 50% of these shared costs. No party shall be liable for the other party's legal fees, except in the cases where the arbitrator determines that the Dispute was brought in bad faith or that a party acted in an unreasonable or egregious manner. During the arbitration proceeding, both parties shall continue to perform their obligations under this Agreement unless the arbitrator specifically rules to suspend certain terms pending the resolution of the Dispute. Either party may seek emergency injunctive relief from the Clackamas County Circuit Court of the Portland based Federal District Court of Oregon to prevent a material breach of this Agreement. However, the party seeking relief shall pursue arbitration at the earliest reasonable opportunity after seeking injunctive relief. The parties agree to keep all details of the arbitration proceedings confidential, with the exception of filing documents in court to enforce or compel arbitration. In such cases, the only part of the Agreement that can be filed in court is Section 6.2. Nothing in this Article shall limit either party's right to terminate this Agreement with or without cause as provided in Section 7.2.

ARTICLE VII - TERM AND TERMINATION

7.1. Term. This Agreement is effective as of the Health Plan Effective Date, and will remain in effect for an initial term ("Initial Term") of 5 year(s), after which it will automatically renew for two terms of 5 years each (each a "Renewal Term"), unless this Agreement is sooner terminated as provided in this Agreement or either Party gives the other Party written notice of non-renewal of this Agreement not less than 180 days prior to the end of the then-current term. In addition, either Party may elect to not renew a Contracted Provider's participation as a Participating Provider in a particular Product for the next Renewal Term, by giving the other Party written notice of such non-renewal not less than 180 days prior to the, as applicable, last day of the Initial Term or applicable Renewal

Term; in such event, Provider shall immediately notify the affected Contracted Provider of such non-renewal. Termination of any Contracted Provider's participation in a particular Product will not have the effect of terminating either this Agreement or the Contracted Provider's participation in any other Product in which the Contracted Provider participates under this Agreement.

7.2. Termination. This Agreement, or the participation of Provider or a Contracted Provider as a Participating Provider in one or more Products, may be terminated or suspended as set forth below.

7.2.1. Upon Notice. This Agreement may be terminated by either Party giving the other Party at least 180 days prior written notice of such termination. The participation of any Contracted Provider as a Participating Provider in a Product may be terminated by either Party giving the other Party at least 180 days prior written notice of such termination; in such event, Provider shall immediately notify the affected Contracted Provider of such termination.

7.2.2. With Cause. This Agreement, or the participation of any Contracted Provider as a Participating Provider in one or more Products under this Agreement, may be terminated by either Party giving at least 60 days prior written notice of termination to the other Party if such other Party (or the applicable Contracted Provider) is in breach of any material term or condition of this Agreement and such other Party (or the Contracted Provider) fails to cure the breach within the 60 day period immediately following the giving of written notice of such breach. Any notice given pursuant to this Section 7.2.2 must describe the specific breach. In the case of a termination of a Contracted Provider, Provider shall immediately notify the affected Contracted Provider of such termination.

7.2.3. Suspension of Participation. Unless expressly prohibited by applicable Regulatory Requirements, Health Plan has the right to immediately suspend or terminate the participation of a Contracted Provider in any or all Products by giving written notice thereof to Provider when Health Plan determines that (i) based upon available information, the continued participation of the Contracted Provider appears to constitute an immediate threat or risk to the health, safety or welfare of Covered Persons, or (ii) has failed to meet objective patient care quality standards, or (iii) the Contracted Provider's fraud, malfeasance or non-compliance with Regulatory Requirements is reasonably suspected. Provider shall immediately notify the affected Contracted Provider of such suspension. During such suspension, the Contracted Provider shall, as directed by Health Plan, discontinue the provision of all or a particular Covered Service to Covered Persons. During the term of any suspension, the Contracted Provider shall notify Covered Persons that his or her status as a Participating Provider has been suspended. Such suspension will continue until the Contracted Provider's participation is reinstated or terminated.

7.2.4. Insolvency. This Agreement may be terminated immediately by a Party giving written notice thereof to the other Party if the other Party is insolvent or has bankruptcy proceedings initiated against it.

7.2.5. Credentialing. The status of a Contracted Provider as a Participating Provider in one or more Products may be terminated immediately by Health Plan giving written notice thereof to Provider if the Contracted Provider fails to adhere to Health Plan's credentialing criteria, including, but not limited to, if the Contracted Provider (i) loses, relinquishes, or has materially affected its license to provide Covered Services in the State, (ii) fails to comply with the insurance requirements set forth in this Agreement; or (iii) is convicted of a criminal offense related to involvement in any state or federal health care program or has been terminated, suspended, barred, voluntarily withdrawn as part of a settlement agreement, or otherwise excluded from any state or federal health care program. Provider shall immediately notify the affected Contracted Provider of such termination.

7.3. Effect of Termination. After the effective date of termination of this Agreement or a Contracted Provider's participation in a Product, this Agreement shall remain in effect for purposes of those obligations and rights arising prior to the effective date of termination. Upon such a termination, each affected Contracted Provider (including Provider, if applicable) shall (i) continue to provide Covered Services to Covered Persons in the applicable Product(s) during the longer of the 90 day period following the date of such termination or such other period as may be required under any Regulatory Requirements, and, if requested by Company, each affected Contracted Provider (including Provider, if applicable) shall continue to provide, as a Participating Provider, Covered Services to Covered Persons until such Covered Persons are assigned or transferred to another Participating Provider in the applicable

Product(s), and (ii) continue to comply with and abide by all of the applicable terms and conditions of this Agreement, including, but not limited to, Section 3.4 (Hold Harmless) hereof, in connection with the provision of such Covered Services during such continuation period. During such continuation period, each affected Contracted Provider (including Provider, if applicable) will be compensated in accordance with this Agreement and shall accept such compensation as payment in full.

7.4. Survival of Obligations. All provisions hereof that by their nature are to be performed or complied with following the expiration or termination of this Agreement, including without limitation Sections 2.8, 2.10, 3.2, 3.4, 3.5, 4.2, 5.1, 5.2, 5.3, 6.2, 7.3, and 7.4 and Article VIII, survive the expiration or termination of this Agreement.

ARTICLE VIII - MISCELLANEOUS

8.1. Relationship of Parties. The relationship between or among Health Plan, Company, Provider, Payor and any Contracted Provider hereunder is that of independent contractors. None of the provisions of this Agreement will be construed as creating any agency, partnership, joint venture, employee-employer, or other relationship. References herein to the rights and obligations of any Company or Health Plan, as applicable, under this Agreement are references to the rights and obligations of each such Company of Health Plan individually and not collectively. A Company or a Health Plan is only responsible for performing its respective obligations hereunder with respect to a particular Product, Coverage Agreement, Payor Contract, Covered Service or Covered Person. A breach or default by an individual Company or Health Plan shall not constitute a breach or default by any other Company or Health Plan.

8.2. Conflicts Between Certain Documents. If there is any conflict between this Agreement and the Provider Manual, this Agreement will control. In the event of any conflict between this Agreement and any Product Attachment, the Product Attachment will control as to such Product.

8.3. Assignment. This Agreement is intended to secure the services of and be personal to Provider and may not be assigned, sublet, delegated, subcontracted or transferred by Provider without Health Plan's prior written consent, which consent shall not be unreasonably withheld or delayed. Health Plan shall have the right, exercisable in its sole discretion, to assign or transfer all or any portion of its rights or to delegate all or any portion of its interests under this Agreement or any Attachment to an Affiliate, successor of Health Plan, or purchaser of the assets or stock of Health Plan, or the line of business or business unit primarily responsible for carrying out Health Plan's obligations under this Agreement, provided that Health Plan provides written notice to the Provider at least 30 days prior to such assignment or transfer. Health Plan (or any successor assignee) may assign one or more Product Attachments to an Affiliate. Following such assignment, Health Plan will retain all rights, title, and interests in and to the Product Attachments that are not assigned, and Health Plan will be released from all liabilities and obligations arising on or after the date of the assignment under the Product Attachments that are assigned. Notwithstanding the foregoing, any successor assigned (whether Affiliate or otherwise) will be fully liable for all the Health Plan's obligations under this Agreement, including those obligations arising after the date of assignment, and shall be bound by all terms and conditions of this Agreement and any Product Attachments. For the purposes of this paragraph, the term "Product Attachment" will refer collectively to the applicable Product Attachment or any portions thereof, as well as this Agreement (including one or more schedules, exhibits and attachments) as it relates to such Product Attachment or portions thereof.

8.4. Headings. The headings of the sections of this Agreement are inserted merely for the purpose of convenience and do not limit, define, or extend the specific terms of the section so designated.

8.5. Governing Law. The interpretation of this Agreement and the rights and obligations of Health Plan, Company, Provider and any Contracted Providers hereunder will be governed by and construed in accordance with applicable federal and State laws.

8.6. Third Party Beneficiary. This Agreement is entered into by the Parties signing it for their benefit, as well as, in the case of Health Plan, the benefit of Company, and in the case of Provider, the benefit of each Contracted

Provider. Except as specifically provided in Section 3.4 hereof, no Covered Person or third party, other than Company, will be considered a third party beneficiary of this Agreement.

8.7. Amendment. Except as otherwise provided in this Agreement, this Agreement may be amended only by mutual written agreement of duly authorized representatives of the Parties.

8.7.1. Health Plan may amend this Agreement by giving Provider written electronic notice of the amendment to the extent such amendment is deemed necessary or appropriate by Health Plan to comply with any Regulatory Requirements. Any such amendment will be deemed accepted by Provider upon the giving of such notice.

8.7.2. Health Plan may amend this Agreement by giving Provider written notice (electronic or paper) of the proposed amendment. Unless Provider notifies Health Plan in writing of its objection to such amendment during the 30 day period following the giving of such notice by Health Plan, Provider shall be deemed to have accepted the amendment.

8.8. Entire Agreement. All prior or concurrent agreements, promises, negotiations or representations either oral or written, between Health Plan and Provider relating to a subject matter of this Agreement, which are not expressly set forth in this Agreement, are of no force or effect.

8.9. Severability. The invalidity or unenforceability of any terms or provisions hereof will in no way affect the validity or enforceability of any other terms or provisions.

8.10. Waiver. The waiver by either Party of the violation of any provision or obligation of this Agreement will not constitute the waiver of any subsequent violation of the same or other provision or obligation.

8.11. Notices. Except as otherwise provided in this Agreement, any notice required or permitted to be given hereunder is deemed to have been given when such written notice has been personally delivered or deposited in the United States mail, postage paid, or delivered in hard copy or electronically by a service that provides written receipt or acknowledgment of delivery, addressed as follows:

To Health Plan at:	To Provider at:
Attn: President	Attn: Administrator
Health Net Health Plan of Oregon, Inc.	County of Clackamas, Oregon
13221 SW 68th Pkwy, Suite 200	2121 Kaen Road
Tigard, OR 97223	Oregon City, Oregon 97045
	vlindley@clackamas.us

or to such other address as such Party may designate in writing. Notwithstanding the previous paragraph, Health Plan may provide notices by electronic mail, through its provider newsletter or on its provider website.

8.12. Force Majeure. Neither Party shall be liable or deemed to be in default for any delay or failure to perform any act under this Agreement resulting, directly or indirectly, from acts of God, civil or military authority, acts of public enemy, war, riots, civil disorders, accidents, fires, explosions, earthquake, flood, lockouts, strikes or other work stoppages by either Party's employees, injunctions-intervention-acts, a governmental authority's failure or refusal to act, or any other similar cause beyond the reasonable control of the affected Party which that Party is unable to prevent by exercising reasonable diligence and that occurs without that Party's fault or negligence.

8.13. Proprietary Information. Each Party agrees not to, and shall ensure that its Affiliates and Contracted Providers do not disclose to a third party the substance of the Agreement or any information of a confidential or proprietary nature acquired from the other Party (or any Affiliate or Contracted Provider thereof) during the course of this Agreement, except as necessary for the performance of this Agreement, to agents or employees of the Party

involved who have a need to know and are bound by confidentiality obligations, or as required by a Payor Contract or applicable Regulatory Requirements. Provider acknowledges that Health Plan considers certain information related to the Health Plan's programs, policies, protocols, and procedures to be proprietary to the Health Plan, and excepts as otherwise provided in this paragraph, Provider shall not disclose such information to any person or entity without Health Plan's express written consent. However, Provider shall not be prohibited from sharing proprietary information with its employees, subcontractors, or other relevant parties to the extent necessary for fulfilling Provider's duties under this Agreement, provided that such parties are bound by confidentiality obligations consistent with the terms of this Agreement. Provider may disclose proprietary information if required by Oregon public records law or other applicable legal requirements, in which case Provider shall give the Health Plan reasonable notice of such required disclosure so that the Health Plan may take steps to protect the confidentiality of the information, if possible. Additionally, Provider shall have the right to use any information necessary in the general course of business, as long as no confidential or proprietary information of the Health Plan is disclosed in the process.

8.14. Authority. The individuals whose signatures are set forth below represent and warrant that they are duly empowered to execute this Agreement. Provider represents and warrants that it has all legal authority to contract on behalf of and to bind all Contracted Providers to the terms of the Agreement with Health Plan.

8.15. Rights and Obligations of Health Plan, Payor. Provider and each Contracted Provider acknowledges that references herein to the rights and obligations of any "Health Plan" or a "Payor" under this Agreement are references to the rights and obligations of such Health Plan and Payor individually and not of the Company or Payors collectively. Each Health Plan and/or Payor is only responsible for performing its obligations hereunder with respect to those Products, Coverage Agreements, Payor Contracts, Covered Services or Covered Persons furnished by, entered into with, enrolled in or relating to such Health Plan or Payor. References to each Company as "Health Plan" herein in no way imposes any cross-guarantees or joint responsibility or liability by, between or among such individual Company. A breach or default by an individual Health Plan or Payor shall not constitute a breach or default by any other Company or Payor, and the exercise of any right under this Agreement by or as relating to Health Plan or Payor does not by operation of this Agreement constitute the exercise of such right by or relating to any other Company, Payor or other entity.

8.16 Attorney Fees. In any proceeding to enforce or interpret this Agreement, seeking to enforce or invalidate an arbitration award, or otherwise arising out of or related to this Agreement, each Party shall be responsible for its own attorneys' fees and costs unless otherwise expressly provided in this Agreement.

* * * * *

THIS AGREEMENT CONTAINS A BINDING ARBITRATION PROVISION THAT MAY BE ENFORCED BY THE PARTIES.

IN WITNESS WHEREOF, the Parties hereto have executed this Agreement, including all Product Attachments noted on Schedule B, effective as of the date set forth beneath their respective signatures.

HEALTH PLAN:	**PROVIDER:**
Health Net Health Plan of Oregon, Inc.	County of Clackamas, Oregon (Legibly Print Name of Provider)
Authorized Signature:	Authorized Signature:
Print Name: Sarah Brewer	Print Name:
Title: Plan President & CEO	Title:
Signature Date:	Signature Date:
ICM #: ICMProviderAgreement_348571	Tax Identification Number: 93-6002286
To be completed by Health Plan only: Effective Date: July 1, 2025	National Provider Identifier: 1720017809 Medicare Number:

PARTICIPATING PROVIDER AGREEMENT

SCHEDULE A
CONTRACTED PROVIDER-SPECIFIC PROVISIONS

Provider and Contracted Providers shall comply with the applicable provisions of this Schedule A.

1. Hospitals. If Provider or a Contracted Provider is a hospital ("Hospital"), the following provisions apply.

1.1 24 Hour Coverage. Each Hospital shall be available to provide Covered Services to Covered Persons twenty-four (24) hours per day, seven (7) days per week.

1.2 Emergency Care. Each Hospital shall provide Emergency Care (as hereafter defined) in accordance with Regulatory Requirements. The Contracted Provider shall notify Company's medical management department of any emergency room admissions by electronic file sent within 24 hours or by the next business day of such admission. "Emergency Care" (or derivative thereof) has, as to each particular Product, the meaning set forth in the applicable Coverage Agreement or Product Attachment. If there is no definition in such documents, "Emergency Care" means inpatient and/or outpatient Covered Services furnished by a qualified provider that are needed to evaluate or stabilize an Emergency Medical Condition. "Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.

1.3 Staff Privileges. Each Hospital shall assist in granting staff privileges or other appropriate access to Company's Participating Providers who are qualified medical or osteopathic physicians, provided they meet the reasonable standards of practice and credentialing standards established by the Hospital's medical staff and bylaws, rules, and regulations.

1.4 Discharge Planning. Each Hospital agrees to cooperate with Company's system for the coordinated discharge planning of Covered Persons, including the planning of any necessary continuing care.

1.5 Credentialing Criteria. Each Hospital shall: (a) currently, and for the duration of this Agreement, remain accredited by the Joint Commission or American Osteopathic Association, as applicable; and (b) ensure that all employees of Hospital perform their duties in accordance with all applicable local, State and federal licensing requirements and standards of professional ethics and practice.

1.6 National Committee for Quality Assurance ("NCQA") Accreditation of Health Plans Standards. Each Hospital agrees to: (i) cooperate with Quality Management and Improvement ("QI") activities; (ii) maintain the confidentiality of a Covered Persons information and records pursuant to the Agreement; and (iii) allow the Company to use Hospital's performance data.

2. Practitioners. If Provider or Contracted Provider is a physician or other health care practitioner (including physician extenders) ("Practitioner"), the following provisions apply.

2.1 Contracted Professional Qualifications. At all times during the term of this Agreement, Practitioner shall, as applicable, maintain medical staff membership and admitting privileges with at least one hospital that is a Participating Provider ("Participating Hospital") with respect to each Product in which the Practitioner participates. Upon Company's request, Practitioner shall furnish evidence of the foregoing to Company. If Practitioner does not have such admitting privileges, Provider or the Practitioner shall provide Company with a written statement from another Participating Provider who has such admitting privileges, in good standing, certifying

that such individual agrees to assume responsibility for providing inpatient Covered Services to Covered Persons who are patients of the applicable Practitioner.

2.2 Acceptance of New Patients. To the extent that Practitioner is accepting new patients, such Practitioner must also accept new patients who are Covered Persons with respect to the Products in which such Practitioner participates. Practitioner shall notify Company in writing 45 days prior to such Practitioner's decision to no longer accept Covered Persons with respect to a particular Product. In no event will an established patient of any Practitioner be considered a new patient.

2.3 Preferred Drug List/Drug Formulary. If applicable to the Covered Person's coverage, Practitioners shall use commercially reasonable efforts, when medically appropriate under the circumstances, to comply with formulary or preferred drug list when prescribing medications for Covered Persons.

2.4 National Committee for Quality Assurance ("NCQA") Accreditation of Health Plans Standards. Each Practitioner agrees to: (i) cooperate with Quality Management and Improvement ("QI") activities; (ii) maintain the confidentiality of a Covered Persons information and records pursuant to the Agreement; and (iii) allow the Company to use Practitioner's performance data.

3. Ancillary Providers. If Provider or Contracted Provider is an ancillary provider (including but not limited to a home health agency, durable medical equipment provider, sleep center, pharmacy, ambulatory surgery center, nursing facility, laboratory or urgent care center)("Ancillary Provider"), the following provisions apply.

3.1 Acceptance of New Patients. To the extent that Ancillary Provider is accepting new patients, such Ancillary Provider must also accept new patients who are Covered Persons with respect to the Products in which such Ancillary Provider participates. Ancillary Provider shall notify Company in writing 45 days prior to such Ancillary Provider's decision to no longer accept Covered Persons with respect to a particular Product. In no event will an established patient of any Ancillary Provider be considered a new patient.

3.2 National Committee for Quality Assurance ("NCQA") Accreditation of Health Plans Standards. Each ancillary provider agrees to: (i) cooperate with Quality Management and Improvement ("QI") activities; (ii) maintain the confidentiality of a Covered Persons information and records pursuant to the Agreement; and (iii) allow the Company to use ancillary provider's performance data.

4. FQHC. If Provider or a Contracted Provider is a federally qualified health center ("FQHC"), the following provision applies.

4.1 FQHC Insurance. To the extent FQHC's employees are deemed to be federal employees qualified for protection under the Federal Tort Claims Act ("FTCA") and Health Plan has been provided with documentation of such status issued by the U.S. Department of Health and Human Services (such status to be referred to as "FTCA Coverage"), Section 5.1 of this Agreement will not apply to those Contracted Providers with FTCA Coverage. FQHC shall provide evidence of such FTCA Coverage to Health Plan at any time upon request. FQHC shall promptly notify Health Plan if, any time during the term of this Agreement, any Contracted Provider is no longer eligible for, or if FQHC becomes aware of any fact or circumstance that would jeopardize, FTCA Coverage. Section 5.1 of this Agreement will apply to a Contracted Provider immediately upon such Contracted Provider's loss of FTCA Coverage for any reason.

5. Facility Providers. If Provider or a Contracted Provider is a facility (including but not limited to Clinic, FQHC, LTAC, Nursing Home, Rehab, Rural Health Clinic, Skilled Nursing) ("Facility Provider") the following provision applies.

5.1 National Committee for Quality Assurance ("NCQA") Accreditation of Health Plans Standards. Each facility agrees to: (i) cooperate with Quality Management and Improvement ("QI") activities; (ii) maintain the confidentiality of a Covered Persons information and records pursuant to the Agreement; and (iii) allow the Company to use facility's performance data.

6. Long Term Services and Supports ("LTSS") and Home and Community-Based Services ("HCBS") Providers. If Provider or a Contracted Provider is a provider of LTSS and/or HCBS services, the following provisions apply.

6.1 Definition. LTSS generally includes assistance with daily self-care activities (e.g., walking, toileting, bathing, and dressing) and activities that support an independent lifestyle (e.g., food preparation, transportation, and managing medications). The broad category of LTSS also includes care and service coordination for people who live in their own home, a residential setting, a nursing facility, or other institutional setting. Home and community-based services ("HCBS") are a subset of LTSS that functions outside of institutional care to maximize independence in the community.

6.2 HCBS Waiver Authorization. Provider shall not provide HCBS Covered Services to Covered Person without the required HCBS waiver authorization.

6.3 Conditions for Reimbursement. No payment shall be made to the Provider unless the Provider has strictly conformed to the policies and procedures of the HCBS Waiver Program, including but not limited to not providing HCBS Covered Services without prior authorization of Health Plan. For the purposes of this Exhibit, "HCBS Waiver Program" shall mean any special Medicaid program operated under a waiver approved by the Centers for Medicare and Medicaid Services which allows the provision of a special package of approved services to Covered Person.

6.4 Acknowledgement. Health Plan acknowledges that Provider is a provider of LTSS and is not necessarily a provider of medical or health care services. Nothing in this Agreement is intended to require Provider to provide medical or health care services that Provider does not routinely provide, but would not prohibit providers from offering these services, as appropriate.

6.5 Notification Requirements. Provider or the applicable Contracted Provider shall provide the following notifications to Health Plan, via written notice or via telephone contact at a number to be provided by Health Plan, within the following time frames:

6.5.1 Provider or the applicable Contracted Provider shall notify Health Plan of a Covered Person's visit to urgent care or the emergency department of any hospital, or of a Covered Person's hospitalization, within 24 hours of becoming aware of such visit or hospitalization.

6.5.2 Provider or the applicable Contracted Provider shall notify Health Plan of any change to the designated/assigned services being provided under a Covered Person's plan of care and/or service plan, within 24 hours of becoming aware of such change.

6.5.3 Provider or the applicable Contracted Provider shall notify Health Plan if a Covered Person misses an appointment with Provider, within 24 hours of becoming aware of such missed appointment.

6.5.4 Provider or the applicable Contracted Provider shall notify Health Plan of any change in a Covered Person's medical or behavioral health condition, within 24 hours of becoming aware of such change. (Examples of changes in condition are set forth in the Provider Manual.)

6.5.5 Provider or the applicable Contracted Provider shall notify Health Plan of any safety issue identified by Provider or Contracted Provider or its agent or subcontractor, within 24 hours of the identification of such safety issue. (Examples of safety issues are set forth in the Provider Manual.)

6.5.6 Provider or the applicable Contracted Provider shall notify Health Plan of any change in Provider's or Contracted Provider's key personnel, within 24 hours of such change.

6.6 Minimum Data Set. If Contracted Provider is a nursing facility, Provider or such Contracted Provider shall submit to Health Plan or its designee the Minimum Data Set as defined by CMS and required under federal law and Health Plan policy as it relates to all Covered Persons who are residents in Contracted Provider's facility. Such submission shall be via electronic mail, facsimile transmission, or other manner and format reasonably requested by Health Plan.

6.7 Quality Improvement Plan. Each Contracted Provider shall participate in Health Plan's LTSS quality improvement plan. Each Contracted Provider shall permit Health Plan to access such Contracted Providers' assessment and quality data upon reasonable advance notice, which may be given by electronic mail.

6.8 Electronic Visit Verification. If Contracted Provider provides in-home services, Contracted Provider shall comply with 21st Century Cures Act and Health Plan's electronic visit verification system requirements where applicable and accessible.

6.9 Criminal Background Checks. Provider shall conduct a criminal background check on each Contracted Provider prior to the commencement of services under this Agreement and as requested by Health Plan thereafter. Provider shall provide the results of such background checks to Health Plan and member, if self-directed, upon request. Provider agrees to immediately notify Health Plan of any criminal convictions of any Contracted or sub-contracted Provider. Provider shall pay any costs associated with such criminal background checks.

7. Person-Centered Planning, Care/Service Plan, and Services ("PCSP"). Provider shall comply with all state and federal regulatory requirements related to person-centered planning, care/service plans, and services including, but not limited to:

7.1 Covered Persons shall lead the person-centered planning process and can elect to include, and/or consult with, any of their LTSS providers in the care/service plan development process.

7.2 The care/service plan must be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation through the mechanism required by state and federal requirements. Non-medical service providers (such as meals or assistive technology) can signify their agreement through this contract or written agreement in lieu of directly in the plan, if permitted by the Covered Persons.

7.3 LTSS Provider shall be aware of, respect, and adhere to a Covered Person's preferences for the delivery of services and supports.

7.4 LTSS Provider shall ensure services and supports are culturally appropriate, provided in plain language (where applicable), and accessible to Covered Persons and the person(s) supporting them who have disabilities and/or are limited English proficient.

7.5 Health Plan agrees to complete the care/service plan in a timely manner (within at least one hundred twenty (120) days of enrollment or annually, or less if state requirements differ) and provide a copy to LTSS Provider(s) responsible for implementation.

7.6 Any Covered Persons communications furnished by Subcontractor shall be subject to review and approval by Contractor and shall contain Contractor's name.

7.7 Notwithstanding any provision of this Agreement, Contractor may terminate this Agreement immediately in the event that Contractor reasonably determines that the continuation of this Agreement presents a risk to Covered Persons health and safety.

PARTICIPATING PROVIDER AGREEMENT

SCHEDULE B
PRODUCT PARTICIPATION

Provider will be designated as a "Participating Provider" in the Product Attachments listed below as of the date of successful completion of credentialing in accordance with this Agreement.

List of Product Attachments:

Attachment A: Medicaid
Attachment B: [Reserved]
Attachment C: [Reserved]
Attachment D: [Reserved]
Attachment E: [Reserved]

PARTICIPATING PROVIDER AGREEMENT

SCHEDULE C
INFORMATION FOR CONTRACTED PROVIDERS

Provider shall provide Health Plan with the information set forth below with respect to: (i) Provider; (ii) each Contracted Provider; and (iii) if applicable, each Contracted Provider's locations and/or professionals. To the extent Provider provides the name of any Contracted Provider to Health Plan hereunder, such entity and/or individual will be considered a Contracted Provider under this Agreement regardless of whether the complete list of information set forth below relating to such Contracted Provider is provided by Provider.

1. Name
2. Address
3. E-mail address
4. Telephone and facsimile numbers
5. Professional license numbers
6. Medicare/Medicaid ID numbers
7. Federal tax ID numbers
8. Completed W-9 form
9. National Provider Identifier (NPI) numbers
10. Provider Taxonomy Codes
11. Area of medical specialty
12. Age restrictions (if any)
13. Area hospitals with admitting privileges (where applicable)
14. Whether Providers are employed or subcontracted with Contracted Provider using the designation "E" for employed or "C" for subcontracted.
15. For a subcontracted Provider, whether its Providers are employed or contracted with the subcontracted Provider using the designation "E" for employed or "C" for contracted.
16. Office contact person
17. Office hours
18. Billing office
19. Billing office address
20. Billing office telephone and facsimile numbers
21. Billing office e-mail address
22. Billing office contact person
23. Ownership Disclosure Form, as required to comply with Regulatory Requirements and Governmental Contract

NOTE: For a complete listing of the information and additional documentation required, please refer to the enrollment application.

Attachment A: Medicaid

MEDICAID PRODUCT ATTACHMENT

THIS PRODUCT ATTACHMENT (this "***Attachment***") is incorporated into the Participating Provider Agreement (the "***Agreement***") is made and entered into by and between County of Clackamas, Oregon ("***Provider***") and Health Net Health Plan of Oregon, Inc.. ("***Health Plan***") (each a "***Party***" and collectively the "***Parties***").

WHEREAS, Health Plan and Provider entered into that certain Participating Provider Agreement, as the same may have been amended and supplemented from time to time (the "***Agreement***"), pursuant to which Provider and its Contracted Providers participate in certain Products offered by or available from or through a Company;

WHEREAS, pursuant to the provisions of the Agreement, this Attachment is identified on the signature page of the Agreement and, as such, the Contracted Providers identified herein will be designated and participate as "***Participating Providers***" in the Product described in this Attachment; and

WHEREAS, the Agreement is modified or supplemented as hereafter provided.

NOW THEREFORE, in consideration of the recitals, the mutual promises herein stated, the parties hereby agree to the provisions set forth below.

1. Defined Terms. For purposes of the Medicaid Product (as herein defined), the following terms have the meanings set forth below. All capitalized terms not specifically defined in this Attachment will have the meanings given to such terms in the Agreement.

1.1 "***Medicaid Product***" refers to those programs and health benefit arrangements offered by Health Plan or other Company pursuant to contract(s) with one or more state Medicaid agency(ies), or any successors thereto, to provide specified services and goods to covered beneficiaries under state Medicaid-funded program(s) and to meet certain performance standards while doing so (each a "***State Contract***"). The Medicaid Product does not apply to any Coverage Agreements that are specifically covered by another Product Attachment to the Agreement.

2. Medicaid Product.

2.1 Medicaid and/or CHIP Product. This Product Attachment constitutes the "***Medicaid Product Attachment***" and is incorporated into the Agreement between Provider and Health Plan. It supplements the Agreement by setting forth specific terms and conditions that apply to the Medicaid Product with respect to which a Participating Provider has agreed to participate, and with which a Participating Provider must comply in order to maintain such participation. This Attachment applies only to the provision of health care services, supplies or accommodations (including Covered Services) to Covered Persons enrolled in the Medicaid Product.

2.2 Participation. Except as otherwise provided in this Product Attachment or the Agreement, Provider and all Contracted Providers under the Agreement will participate as Participating Providers in the Medicaid Product and will provide to Covered Persons enrolled in the Medicaid Product, upon the same terms and conditions contained in the Agreement, as supplemented or modified by this Product Attachment, those Covered Services that are provided by Contracted Providers pursuant to the Agreement. In providing such services, Provider shall, and shall cause Contracted Providers to, comply with and abide by the provisions of this Product Attachment and the Agreement (including the Provider Manual).

2.3 Attachment. This Attachment constitutes the Product Attachment and Compensation Schedule for the Medicaid Product.

2.4 Construction. This Product Attachment supplements and forms a part of the Agreement. Except as otherwise provided herein or in the terms of the Agreement, the terms and conditions of the Agreement

will remain unchanged and in full force and effect as a result of this Product Attachment. In the event of a conflict between the provisions of the Agreement and the provisions of this Product Attachment, this Product Attachment will govern with respect to health care services, supplies or accommodations (including Covered Services) rendered to Covered Persons enrolled in or covered by a Medicaid Product. To the extent Provider or any Contracted Provider is unclear about its, his or her respective duties and obligations, Provider or the applicable Contracted Provider shall request clarification from Health Plan. To the extent any provision of this Agreement (including any exhibit, attachment, or other document referenced herein) is inconsistent with or contrary to any provision of the State Contract, the relevant provision of the State Contract shall have priority and control over the matter.

3. Term. This Product Attachment will become effective as of the Effective Date, and will be coterminous with the Agreement unless a Party terminates the participation of the Contracted Provider in this Product in accordance with the applicable provisions of the Agreement or this Product Attachment.

4. State Contract Regulatory Requirements. Schedule A to this Product Attachment, which is incorporated herein by this reference, sets forth the provisions that are applicable to the Medicaid Product under the State Contract.

5. Other Terms and Conditions. Except as modified or supplemented by this Product Attachment, the compensation hereunder for the provision of Covered Services by Contracted Providers to Covered Persons enrolled in or covered by the Medicaid Product is subject to all of the other provisions in the Agreement (including the Provider Manual) that affect or relate to compensation for Covered Services provided to Covered Persons.

Attachment A: Medicaid

SCHEDULE A
STATE CONTRACT REGULATORY REQUIREMENTS

Trillium Community Health Plan, Inc. (known in the Agreement as "***Trillium***" and known in this Schedule A as "***Contractor***") has entered into a Health Plan Services Contract, Coordinated Care Organization Contract with the State of Oregon, acting by and through its Oregon Health Authority ("***OHA***"), to provide and pay for Coordinated Care Services (the "***OHP Contract***"). The OHP Contract requires that certain provisions in this Exhibit be included in any subcontracts and contracts with Participating Providers. This Exhibit is incorporated by reference into and made part of the Physician Provider Agreement (the "Agreement") with respect to goods and services rendered under the Agreement by Physician (collectively, with any Participating Providers contracted by Physician, the known in the Agreement as "***Provider***" or "***Contracted Provider***" and known in this Schedule A as "***Subcontractor***") to enrollees of Contractor who are enrolled in the Oregon Health Plan managed care program (known in the Agreement as "***Covered Person(s)***" and known in this Schedule A as "***Members***").

In the event of a conflict or inconsistency with any term or condition in the Agreement relating to goods and services rendered to Members who are enrolled in the Oregon Health Plan managed care program, this Exhibit shall control. Any additional regulatory requirements that may apply with respect to a Member Contract or Members covered by this Exhibit are or will be set forth in the Provider Manual or another Exhibit. To the extent that a Member Contract or a Member is subject to the law cited in the parenthetical at the end of a provision on this Exhibit 1, such provision will apply to the rendering of Covered Services to a Member with such Member Contract, or to such Member, as applicable.

Subcontractor shall comply with the provisions in this Exhibit to the extent that they are applicable to the goods and services provided by Subcontractor under the Agreement; provided, however, that the Agreement shall not terminate or limit Contractor's legal responsibilities to OHA for the timely and effective performance of Contractor's duties and responsibilities under the OHP Contract. Capitalized terms used in this Exhibit, but not otherwise defined herein or in the Agreement shall have the same meaning as those terms in the OHP Contract, including definitions incorporated therein by reference. The current version of the OHP Contract, including the definitions, is publicly available at https://www.oregon.gov/oha/OHPB/Pages/CCO-2-0-Contract-Selection.aspx, or the OHP Contract definitions may be requested from Contractor.

1. **OHA.** To the extent any provision in the OHP Contract applies to Contractor or Subcontractor with respect to the Work that Contractor is providing to OHA or Subcontractor is providing to Contractor through the Agreement and is not set forth in this Exhibit, that provision shall be incorporated by reference into this Exhibit and shall apply equally to Subcontractor. Subcontractor shall perform any services or obligations subcontracted by the Contractor and meet the obligations and terms and conditions of the OHP Contract as if the Subcontractor is the Contractor. Subcontractor acknowledges and agrees that the Agreement: (i) is in writing, (ii) specifies the subcontracted Work and reporting responsibilities, (iii) is in compliance with the requirements described in the OHP Contract, and (iv) hereby incorporates the applicable provisions of the OHP Contract, based on the scope of Work Subcontracted such that the provisions of the Agreement are the same as or substantively similar to the applicable provisions of the OHP Contract. To the extent that Contractor is held liable for a breach of the OHP Contract by Subcontractor, Subcontractor will be liable for Contractor to the same extent, including reimbursement of all penalties, fines and sanctions applied to Contractor due to Subcontractor's breach of the OHP Contract. (*OHP Contract Exhibit B, Part 4, Sections 12, 12.a(2) and 12.a(7)*).

2. **Termination for Cause.** In addition to pursuing any other remedies allowed at law or in equity or by the Agreement, the Agreement may be terminated by Contractor, or Contractor may take remedial actions and impose other sanctions against Subcontractor, if the Subcontractor's performance is inadequate to meet the requirements of the OHP Contract. In addition, Contractor may terminate the Agreement, or require Subcontractor (if it contracts with Participating Providers) to terminate the Subcontractor's agreement with a Participating Provider, immediately upon receipt of Legal Notice from the State that Participating Provider is precluded from being enrolled as a Medicaid Provider. (*OHP Contract Exhibit B, Part 4, Section 5.a(6) and 12.b(1)(a)*)

3. **Monitoring.**

3.1 By Contractor. Subcontractor acknowledges and agrees Contractor has the right to monitor the Subcontractor's performance on an ongoing basis, including performing an annual formal review of compliance with delegated responsibilities, and Subcontractor's performance, deficiencies or areas for improvement, in accordance with 42 CFR § 438.230. Upon identification of deficiencies or areas for improvement, Subcontractor shall take the corrective actions identified by Contractor in a Corrective Action Plan to remedy such deficiencies. If deficiencies are identified in Subcontractor's performance for any functions outlined in the OHP Contract, whether those are identified by Contractor, by OHA or their respective designees, Subcontractor will respond and remedy those deficiencies within the timeframe determined by OHA. Contractor may revoke the delegation of activities or obligations or pursue other remedies in accordance with the Agreement in instances where OHA or the Contractor determines the Subcontractor has breached the terms of the Agreement. (*OHP Contract Exhibit B, Part 4, Sections 12.a(10), 12.a.16 and 12.b.(1)(b); Exhibit I, Section 1(e)(10)*)

3.2 By OHA. Subcontractor agrees that OHA is authorized to monitor compliance with the requirements in the Statement of Work under the OHP Contract and that methods of monitoring compliance may include review of documents submitted by Subcontractor, OHP Contract performance review, Grievances, on-site review of documentation or any other source of relevant information. *(OHP Contract Exhibit B Part 9, Section 1.a.)*

4. **Required Subcontractor Provisions.**

4.1 Subcontractor will comply with the payment, withholding, incentive and other requirements of 42 CFR §438.6 that are applicable to the Work required under the Agreement. (*OHP Contract Exhibit B, Part 4, Section 12.b(1)(c)*)

4.2 Subcontractor will submit to Contractor Valid Claims for services including all the fields and information needed to allow the claim to be processed without further information from the Provider within timeframes for valid, accurate, Encounter Data submission as required under the OHP Contract. Subcontractor will document, maintain and provide to Contractor all Encounter Data records that document Subcontractor's reimbursement to FQHCs, Rural Health Centers and Indian Health Care providers. Subcontractor will provide all such documents to Contractor upon request of Contractor. (*OHP Contract Exhibit B, Part 4, Sections 12.b(1)(d) and 12.c*)

4.3 Subcontractor agrees to comply with all Applicable Laws, including, without limitation, all Medicaid laws, rules, regulations, as well as all applicable sub-regulatory guidance and contract provisions. (*OHP Contract Exhibit B, Part 4, Section 12.b(1)(e)*)

4.4 Subcontractor agrees that OHA, the Oregon Secretary of State, CMS, HHS, the Office of the Inspector General, the Comptroller General of the United States, or their duly authorized representatives and designees, or all of them or any combination of them, have the right to audit, evaluate, and inspect any books, records, contracts, computers or other electronic systems of the Subcontractor, or of the Subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the OHP Contract. (*OHP Contract Exhibit B, Part 4, Section 12.b(1)(f)*)

4.5 Subcontractor will make available, for purposes of audit, evaluation, or inspection its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems relating to its Medicaid Members. (*OHP Contract Exhibit B, Part 4, Section 12.b(1)(g)*)

4.6 Subcontractor must respond and comply in a timely manner to any and all requests from OHA or its designee for information or documentation pertaining to Work outlined in the OHP Contract. (*OHP Contract Exhibit B, Part 4, Section 12.b(1)(h)*)

4.7 Subcontractor agrees that the right to audit by OHA, CMS, the DHHS Inspector General, the Comptroller General or their designees, will exist for a period of ten (10) years from the Expiration Date of the OHP Contract or from the date of completion of any audit, whichever is later. (*OHP Contract Exhibit B, Part 4, Section 12.b(1)(i)*)

4.8 If OHA, CMS, or the DHHS Inspector General determine that there is a reasonable possibility of fraud or similar risk, OHA, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the Subcontractor at any time. (*OHP Contract Exhibit B, Part 4, Section 12.b(1)(j)*)

4.9 Subcontractor will adopt and comply with all of Contractor's Fraud, Waste, and Abuse policies, procedures, reporting obligations, and annual Fraud, Waste, and Abuse Prevention Plan. Subcontractor will comply with and perform all of the same obligations, terms and conditions of Contractor as set forth in Part 9 of the OHP Contract. Unless expressly provided otherwise in the applicable provision, Subcontractor must report any Provider and Member Fraud, Waste, or Abuse to Contractor, and Contractor will be responsible for reporting to OHA or the applicable agency, division, or entity. Accordingly, the timing for reporting obligations of Subcontractor are shorter than those of Contractor's time for reporting to OHA so that Contractor may timely report such incidents to OHA in accordance with the OHA Contract. (*OHP Contract Exhibit B, Part 4, Section 12.b(1)(k)*)

4.10 Subcontractor will allow Contractor to perform Monitoring, audit, and other review processes for the purpose of determining and reporting on compliance with the terms and conditions of the Agreement, including, without limitation, compliance with Medical and other records security and retention policies and procedures. (*OHP Contract Exhibit B, Part 4, Section 12.b(1)(l)*)

4.11 Subcontractor will report any Other Primary, third-party Insurance to which a Member may be entitled. Subcontractor must report such information to Contractor within a timeframe that enables Contractor to report such information to OHA within thirty (30) days of the Subcontractor becoming aware that the applicable Member has such coverage, as required under Section 16, Exhibit B, Part 8 of the OHP Contract. (*OHP Contract Exhibit B, Part 4, Section 12.b(1)(n)*)

4.12 Subcontractors will provide, in a timely manner upon request, as requested by Contractor in accordance with the request made by OHA, or as may be requested directly by OHA, with all Third-Party Liability eligibility information and any other information requested by OHA or Contractor, as applicable, in order to assist in the pursuit of financial recovery. (*OHP Contract Exhibit B, Part 4, Section 12.b(1)(o)*)

5. **Hold Harmless.** Subcontractor understands and agrees that neither OHA nor a Member receiving services are liable for any costs or charges related to Contractor-authorized Covered Services rendered to a Member whether in an emergency or otherwise, including Holistic Care. Furthermore, Subcontractor shall not hold a Member liable for any payments for any of the following: (a) Contractor's or Subcontractor's debt due to Contractor's or Subcontractor's insolvency; (b) Covered Services authorized or required to be provided under the OHP Contract to a Member, for which (i) the State does not pay Contractor; or (ii) Contractor does not pay Subcontractor that furnishes the services under a contractual, referral or other arrangement; or (c) Covered Services furnished pursuant to the Agreement to the extent that those payments are in excess of the amount that the Member would owe if Contractor provided the services directly. Subcontractor may not initiate or maintain a civil action against a Member to collect any amounts owed by the Contractor for which the Member is not liable to the Subcontractor under the Agreement. Nothing in this paragraph 5 shall impair the right of the Subcontractor to charge, collect from, attempt to collect from or maintain a civil action against a Member for any of the following: (a) deductible, copayment, or coinsurance amounts, (b) health services not covered by the Contractor or the OHP Contact, and (c) health services rendered after the termination of the Agreement, unless the health services were rendered during the confinement in an inpatient facility and the confinement began prior to the date of termination of the Agreement or unless the Subcontractor has assumed post-termination treatment obligations under the Agreement. (*OHP Contract Exhibit B Part 8, Section 4.b; Exhibit L, Section 5.a(5)*)

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

7. **Billing and Payment.**

7.1 **Non-Covered Services.** Subcontractor shall not, and will ensure that its subcontractors including any Providers do not, bill Members for services that are not Covered Services under the OHP Contract unless: (a) 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 410-141-3420(5), and (b) the Provider has complied with the requirements set forth in OAR 410-120-1280(3)(h). (*OHP Contract Exhibit B, Part 4, Section 12.a.11; Part 8, Section 4.g*)

7.2 **Claims Submission.** Pursuant to OAR 410-141-3420, Subcontractor must submit all billings for Members to Contractor within four months of the Date of Service. However, Subcontractor may, if necessary, submit its billings to Contractor within twelve (12) months from the date of Service under the following circumstances: (a) billing is delayed due to retroactive deletions or enrollments; (b) pregnancy of the Member; (c) Medicare is the primary payer, unless Contractor is responsible for Medicare reimbursement; (d) cases involving Third-Party Resources; or (e) other cases that delay the initial billing to Contractor, unless the delay was due to the Subcontractor's failure to verify a Member's eligibility. (*OHP Contract Exhibit B, Part 8, Section 5.b*)

7.3 **Provider-Preventable Conditions.** No payment under the Agreement will be made for any Provider-Preventable Conditions or Health Care-Acquired Conditions, as specified in the OHP Contract. Subcontractor will comply with the reporting requirements regarding Provider-Preventable Conditions or Health Care-Acquired Conditions specified by Contractor or OHA as a condition of payment from Contractor. Subcontractor will identify Provider-Preventable Conditions that are associated with claims for CCO Payment or with courses of treatment furnished to Members for which CCO Payment would otherwise be available. (*OHP Contract Exhibit B, Part 8, Section 5.i*)

7.4 **Eligibility Verification.** Subcontractor will verify current Member eligibility using the Automated Voice Response system, 270/271 Health Care Eligibility Benefit Inquiry and Response transactions, or the MMIS Web Portal. (*OHP Contract Exhibit B, Part 8, Section 7.b*)

8. **Record Keeping.** Subcontractor shall provide OHA, its external quality review organization, or any of its other designees, agent or subcontractors (or a combination, or all, of them) with timely access to records and facilities and cooperate with such parties in the collection of information for the purposes of Monitoring compliance with the OHP Contract, including but not limited to verification of services actually provided, and for developing, Monitoring and analyzing performance and outcomes. Collection methods with which Subcontractor must cooperate may include, without limitation: consumer surveys, on-site reviews, medical chart reviews, financial reporting and financial record reviews, interviews with staff, and other means determined by OHA. (*OHP Contract Exhibit B Part 8, Section 1.b)*

9. **Quality Review.** In conformance with 42 CFR § 438.350 and § 438.358, and 42 CFR §457.1250**,** Subcontractor shall permit OHA and its designees to have access to, or provide OHA with, Subcontractor's records and facilities, and information requested by OHA and its designees, for the purpose of an annual External Quality Review of compliance with all Applicable Laws and the OHP Contract as well as the quality outcomes and timeliness of, and access to, services provided under the OHP Contract. (*OHP Contract Exhibit B Part 10, Section 8.a)*

10. **Access to Records.** Subcontractor shall maintain all financial records related to the OHP Contract in accordance with best practices or National Association of Insurance Commissioners accounting standards. In addition, Subcontractor shall maintain any other records, books, documents, papers, plans, records of shipment and payments and writings of Subcontractor, whether in paper, electronic or other form, that are pertinent to the OHP Contract in such a manner as to clearly document Subcontractor's performance. All Clinical Records, financial records, other records, books, documents, papers, plan, records of shipments and payments and writings of Subcontractors whether in paper, electronic or other form, that are pertinent to the OHP Contract, are collectively referred to as "Records". Subcontractor shall ensure timely access to its Records to OHA, the Secretary of State's Office, CMS, the Comptroller General of the United States, DHHS; the Office of the Inspector General, the Comptroller General of the United States, the Oregon Department of Justice Oregon Health Plan Fraud Control Unit;

and their duly authorized representatives for the purpose of performing examinations and audits and making excerpts and transcripts, evaluating compliance with the OHP Contract, and evaluating the quality, appropriateness and timeliness of services. Subcontractor further acknowledges and agrees that the foregoing entities may, at any time, inspect the premises, physical facilities, computer systems and any other equipment and facilities where Medicaid-related activities or Work is conducted or equipment is used (or both conducted and used). The right to audit under this Section exists for 10 years from, as applicable, the Expiration Date or the date of termination, or from the date of completion of any audit, whichever is later. Subcontractor shall, upon request and without charge, provide a suitable work area and copying capabilities to facilitate such a review or audit. The right to audit also includes timely and reasonable access to Subcontractor's personnel and subcontractors for the purpose of interview and discussion related to such documents. Subcontractor shall retain and keep accessible all Records for the longer of ten (10) years: (a) the retention period specified in the OHP Contract for certain kinds of records; (b) the period as may be required by Applicable Law, including the records retention schedules set forth in OAR Chapters 410 and 166; or (c) until the conclusion of any audit, controversy or litigation arising out of or related to the OHP Contract. The rights of access in this paragraph 10 are not limited to the required retention period, but shall last as long as the Records are retained. In accordance with Oregon Enrolled Senate Bill 1041 (2019), Section 54c, OHA has the right to provide the Oregon Department of Consumer and Business Affairs with information reported to OHA by Contractor provided that OHA and DCBS have entered into information sharing agreements that govern the disclosure of such information. (*OHP Contract Exhibit D, Section 15*)

11. **Clinical Records and Confidentiality of Member Records.** Subcontractor shall comply with Contractor's policies and procedures that ensure maintenance of a record keeping system that includes maintaining the security of records as required by the Health Insurance Portability and Accountability Act, 42 USC 1320d et. seq., and the federal regulations implementing the Act (collectively, "HIPAA"), and complete Clinical Records that document the Covered Services provided to Members. Subcontractor shall be subject to and take the corrective actions identified by Contractor in a Corrective Action Plan. (*OHP Contract Exhibit B Part 8, Section 2.a*)

12. **Reporting of Abuse.** Subcontractor shall comply with all patient abuse reporting requirements and fully cooperate with the State for purposes of ORS 410.610 et.seq., ORS 419B.010 et.seq., ORS 430.735 et.seq., ORS 433.705 et.seq., ORS 441.630 et.seq., and all applicable Administrative Rules. In addition, Subcontractor shall comply with all protective services, investigation and reporting requirements described in (a) OAR 407-045-0000 through 407-045-0370 (abuse investigations by the Office of Investigations and Training); (b) ORS 430.735 through 430.765 (persons with mental illness or developmental disabilities); (c) ORS 124.005 to 124.040 (elderly persons and persons with disabilities abuse); and (d) ORS 441.650 to 441.680 (residents of long term care facilities). (*OHP Contract Exhibit D, Section 33.b*)

13. **Fraud and Abuse.** Subcontractor shall comply with Contractor's fraud and Abuse policies to prevent and detect fraud and Abuse activities as such activities relate to the OHP Contract, and shall promptly refer all suspected cases of fraud and Abuse to the Contractor and the Oregon Department of Justice Medicaid Fraud Control Unit ("MFCU"). Subcontractor shall permit the MFCU or OHA or both to inspect, evaluate, or audit books, records, documents, files, accounts, and facilities maintained by or on behalf of Subcontractor, as required to investigate an incident of fraud and Abuse. Subcontractor shall cooperate with the MFCU and OHA investigator during any investigation of fraud and Abuse. Subcontractor shall provide copies of reports or other documentation regarding any suspected fraud at no cost to MFCU or OHA during an investigation *(OHP Contract Exhibit B Part 9, Sections 13 – 17)*

14. **Certification.** Subcontractor represents and warrants that all claims data, either directly or through a third party submitter, is and will be accurate, truthful and complete in accordance with OARs 410-141-3420, 410-141-3430 and OAR 410-120-1280. (*OHP Contract Exhibit J, Section 1.b*)

15. **Mental Health Services and Substance Use Disorder Services.**

15.1 Community Services. If Subcontractor arranges for the provision of substance use disorder services, Subcontractor shall provide to Members, to the extent of available community resources and as Medically Appropriate, 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. (*OHP Contract Exhibit M, Section 7.g*)

15.2 Training. Where Subcontractor provides Substance Use Disorder services and evaluates Members for access to and length of stay in Substance Use Disorder programs and services, Subcontractor represents and warrants that will use the American Society of Addiction Medicine (ASAM) Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition-Revised (PPC-2R) for level of care placement decisions, and that Subcontractor has the training and background to evaluate medical necessity for Substance Use Disorder services using the ASAM. (*OHP Contract Exhibit M, Section 21.e*)

16. **Compliance with Applicable Law.**

16.1 Subcontractor shall comply with all State and local laws, rules, regulations, executive orders and ordinances applicable to the OHP Contract or to the performance of Work under the Agreement, as they may be adopted, amended or repealed form time to time, including but not limited to the following: (a) ORS Chapter 659A.142; (b) OHA rules pertaining to the provision of integrated and coordinated care and services, OAR Chapter 410, Division 141; (c) all other OHA Rules in OAR Chapter 410; (d) rules in OAR Chapter 309, Divisions 012, 014, 015, 018, 019, 022, 032 and 040, pertaining to the provisions of Behavioral Health services; (e) rules in OAR Chapter 415 pertaining to the provision of Substance Use Disorders services; (f) state law establishing requirements for Declaration for Mental Health Treatment in ORS 127.700 through 127.737; and (g) all other applicable requirements of State civil rights and rehabilitation statutes, rules and regulations. These laws, regulations, executive orders and ordinances are incorporated by reference herein to the extent that they are applicable to the OHP Contract and required by law to be so incorporated. OHA's performance under this Contract is conditioned upon compliance with the provisions of ORS 279B.220, ORS 279B.225, 279B.230, 279B.235 and 279B.270, which are incorporated by reference herein. Subontractor shall, to the maximum extent economically feasible in its performance related to the OHP Contract, use recycled paper (as defined in ORS 279A.010(1)(gg)), recycled PETE products (as defined in ORS 279A.010(1)(hh)), and other recycled products (as "recycled product" is defined in ORS 279A.010(1)(ii)). (*OHP Contract Exhibit D, Sections 2.a and 20*)

16.2 Subcontractor shall comply with the federal laws as set forth or incorporated, or both, in the OHP Contract and all other federal laws applicable to Subcontractor's performance in connection with the OHP Contract as they may be adopted, amended or repealed from time to time. (*OHP Contract Exhibit D, Sections 2.c and 20*)

17. **Americans with Disabilities Act.** In compliance with the Americans with Disabilities Act of 1990, any written material that is generated and provided by Subcontractor under the OHP Contract to Clients or Members, including Medicaid-Eligible Individuals, shall, at the request of such Clients or Members, be reproduced in alternate formats of communication, to include Braille, large print, audiotape, oral presentation, and electronic format. Subcontractor shall not be reimbursed for costs incurred in complying with this provision. (*OHP Contract Exhibit D, Section 2.b and 20*)

18. **Information/Privacy/Security/Access.** If the Work performed in connection with the OHP Contract permits Subcontractor to have access to or use of any OHA computer system or other OHA Information Asset for which OHA imposes security requirements, and Subcontractor is granted access to such OHA Information Assets or Network and Information Systems, Subcontractor shall comply with OAR 943-014-0300 through OAR 943-014-0320, 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 943-014-0305, as such rule may be revised from time to time. (*OHP Contract Exhibit D, Sections 16 and 20*)

19. **Governing Law, Consent to Jurisdiction.** The Agreement and the OHP Contract is governed by and construed in accordance with the laws of the State of Oregon without regard to principles of conflicts of law. Any claim, action, suit or proceeding (collectively, the "Claim") between OHA or any other agency or department of the State of Oregon, or both, and Contractor or Subcontractor that arises from or relates to the OHP Contract shall be brought and conducted solely and exclusively within the Circuit Court of Marion County or of Multnomah County for the State of Oregon; provided, however, (a) if federal jurisdiction exists then OHA may remove the Claim to

federal court, and (b) if a Claim must be brought in or is removed to a federal forum, then it shall be brought and conducted solely and exclusively within the United States District Court for the District of Oregon. In no event shall this section be construed as a waiver by the State of Oregon of the jurisdiction of any court or of any form of defense to or immunity from any Claim whether sovereign immunity, governmental immunity, immunity based on the Eleventh Amendment to the Constitution of the United States or otherwise. **SUBCONTRACTOR, BY EXECUTION OF THE AGREEMENT, HEREBY CONSENTS TO THE IN PERSONAM JURISDICTION OF SAID COURTS.** (*OHP Contract Exhibit D, Sections 1 and 20*)

20. **Independent Contractor.**

20.1 Not an Employee of the State. Subcontractor represents and warrants that it is not an officer, employee, or agent of the State of Oregon as those terms are used in ORS 30.265 or otherwise. (*OHP Contract Exhibit D, Sections 3.a and 20*)

20.2 Current Work for State or Federal Government. If Subcontractor is currently performing work for the State of Oregon or the federal government, Subcontractor by signature to the Agreement represents and warrants that Subcontractor's Work to be performed under the Agreement creates no potential or actual conflict of interest as defined by ORS Chapter 244 and that no statutes, rules or regulations of the State of Oregon or federal agency for which Subcontractor currently performs work would prohibit Subcontractor's work under the Agreement or the OHP Contract. If compensation under the Agreement is to be charged against federal funds, Subcontractor certifies that it is not currently employed by the federal government. (*OHP Contract Exhibit D, Sections 3.b and 20*)

20.3 Taxes. Subcontractor is responsible for all federal and State taxes applicable to compensation paid to Subcontractor under the Agreement, and unless Subcontractor is subject to backup withholding, OHA and Contractor will not withhold from such compensation any amount to cover Subcontractor's federal or State tax obligations. Subcontractor is not eligible for any social security, unemployment insurance or workers' compensation benefits from compensation paid to Subcontractor under the Agreement or the OHP Contract, except as a self-employed individual. (*OHP Contract Exhibit D, Sections 3.c and 20*)

20.4 Control. Subcontractor shall perform all Work as an Independent Contractor. Subcontractor agrees that OHA reserves the right (i) to determine and modify the delivery schedule for the Work, and (ii) to evaluate the quality of the Work Product; however, neither OHA nor Contractor will control the means or manner of Subcontractor's performance. Subcontractor is responsible for determining the appropriate means and manner of performing the Work delegated under the Agreement. (*OHP Contract Exhibit D, Sections 3.d and 20*)

21. **Representations and Warranties.** Subcontractor represents and warrants to Contractor and OHA that: (a) Subcontractor has the power and authority to enter into and perform the Agreement; (b) the Agreement, when executed and delivered, shall be a valid and binding obligation of Subcontractor enforceable in accordance with its terms, (c) Subcontractor has the skill and knowledge possessed by well-informed members of its industry, trade or profession and Subcontractor will apply that skill and knowledge with care and diligence to perform the Work in a professional manner and in accordance with standards prevalent in Subcontractor's industry, trade or profession; (d) Subcontractor shall, at all times during the Term of the Agreement, be qualified, professionally competent, and duly licensed to perform the Work; and (e) Subcontractor prepared its application related to the Agreement or OHP Contract, if any, independently from all other Contractors and subcontractors, and without collusion, Fraud or other dishonesty. The warranties set forth in this paragraph are in addition to, and not in lieu of, any other warranties provided. (*OHP Contract Exhibit D, Sections 4 and 20*)

22. **Assignment, Successor in Interest.** Subcontractor shall not assign or transfer its interest in the Agreement or the OHP Contract (if any), voluntarily or involuntarily, whether by merger, consolidation, dissolution, operation of law, or in any other matter, without prior written consent of Contractor and/or OHA. Any such assignment or transfer, if approved, is subject to such conditions and provisions as Contractor or OHA may deem necessary, including but not limited to Exhibit B, Part 8, Section 14 of the OHP Contract. No approval by Contractor or OHA of any assignment or transfer of interest shall be deemed to create any obligation of Contractor or OHA in addition to those set forth in the Agreement or the OHP Contract, respectively. The provisions of the Agreement shall be

binding upon and inure to the benefit of the parties, their respective successors and permitted assigns. (*OHP Contract Exhibit D, Sections 19 and 20*)

23. **Subcontracts of Subcontractor.** Where Subcontractor is permitted to subcontract certain functions of the Agreement, Subcontractor shall notify Contractor, in writing, of any subcontract(s) for any of the Work required under the Agreement and the OHP Contract other than information submitted in Exhibit G of the OHP Contract. In addition, Subcontractor shall ensure that any subcontracts, including any subcontractors with Participating Providers, are in writing and include all the requirements set forth in this Exhibit that are applicable to the service or activity delegated under the subcontract. *(OHP Contract Exhibit B Part 4, Section 12.a.(2))*

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

25. **Limitations of Liabilities.** Subcontractor agrees that neither OHA, Contractor nor a Member will be held liable for any of Subcontractor's debts or liabilities in the event of insolvency. (*OHP Contract Exhibit D, Section 8.d; Exhibit L, Section 5.a(5)(a)*)

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

26.1 Federal Provisions. Subcontractor shall comply with all federal laws, regulations, and executive orders applicable to the OHP Contract or to the delivery of Work under the Agreement. Without limiting the generality of the foregoing, Subcontractor expressly agrees to comply with the following laws, regulations and executive orders to the extent they are applicable to the OHP Contract and the Agreement: (a) Title VI and VII of the Civil Rights Act of 1964, as amended, (b) 45 CFR Part 84 which implements Title V, Sections 503 and 504 of the Rehabilitation Act of 1973, as amended, (c) the Americans with Disabilities Act of 1990, as amended, (d) Section 1557 of the Patient Protection and Affordable Care Act (ACA), (e) Executive Order 11246, as amended, (f) the Health Insurance Portability and Accountability Act of 1996, as amended, (g) the Age Discrimination in Employment Act of 1967, as amended, and the Age Discrimination Act of 1975, as amended, (h) the Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended, (i) the Mental Health Parity and Addiction Equity Act of 2008, as amended; (j) CMS regulations (including 42 CFR Part 438, subpart K) and guidance regarding mental health parity, including 42 CFR 438.900 et. seq.; (k) all regulations and administrative rules established pursuant to the foregoing laws, (l) all other applicable requirements of federal civil rights and rehabilitation statutes, rules and regulations, and (m) all federal law governing operation of community mental health programs, including without limitation, all federal laws requiring reporting of Member abuse. These laws, regulations and executive orders are incorporated by reference herein to the extent that they are applicable to the OHP Contract and the Agreement and required by law to be so incorporated. No federal funds may be used to provide Work in violation of 42 USC 14402. (*OHP Contract Exhibit E, Section 1*)

26.2 Equal Employment Opportunity. If the Agreement, including amendments, is for more than $10,000, then Subcontractor shall comply with Executive Order 11246, entitled "Equal Employment Opportunity," as amended by Executive Order 11375, and as supplemented in Department of Labor regulations (41 CFR Part 60). (*OHP Contract Exhibit E, Section 2*)

26.3 Clean Air, Clean Water, EPA Regulations. If the Agreement, including amendments, exceeds $100,000 then Subcontractor shall comply with all applicable standards, orders, or requirements issued under Section 306 of the Clean Air Act (42 USC 7606), the Federal Water Pollution Control Act as amended (commonly known as

the Clean Water Act) (33 USC 1251 to 1387), specifically including, but not limited to Section 508 (33 USC 1368), Executive Order 11738, and Environmental Protection Agency regulations (2 CFR Part 1532), which prohibit the use under nonexempt federal contracts, grants or loans of facilities included on the EPA List of Violating Facilities. Violations shall be reported in writing to OHA, the U.S. Department of Health and Human Services and the appropriate Regional Office of the Environmental Protection Agency. Subcontractor shall include in all contracts with subcontractors receiving more than $100,000, language requiring the subcontractor to comply with the federal laws identified in this subparagraph. (*OHP Contract Exhibit E, Section 3*)

26.4 Energy Efficiency. Subcontractor shall comply with applicable mandatory standards and policies relating to energy efficiency that are contained in the Oregon energy conservation plan issued in compliance with the Energy Policy and Conservation Act, 42 USC 6201 et seq. (Pub. L. 94-163). (*OHP Contract Exhibit E, Section 4*)

26.5 Truth in Lobbying. By signing the Agreement, Subcontractor certifies, to the best of the Subcontractor's knowledge and belief each of the following.

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

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

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

d. The certification made under this Section is a material representation of fact upon which reliance was placed when the Agreement was made or entered into. (*OHP Contract Exhibit E, Section 5*)

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

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

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

h. No part of any federal funds paid to Subcontractor under the Agreement may be used for any activity that promotes the legalization of any drug or other substance included in schedule I of the schedules of controlled substances established under Section 202 of the Controlled Substances Act except for normal and recognized executive congressional communications. This limitation shall not apply when there is significant medical evidence of a therapeutic advantage to the use of such drug or other substance of that federally sponsored clinical trials are being conducted to determine therapeutic advantage. (*OHP Contract Exhibit E, Section 5*)

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

a. Privacy and Security of Individually Identifiable Health Information. Individually Identifiable Health Information ("IIHI") about specific individuals is protected from unauthorized use or disclosure consistent with the requirement of HIPAA. IIHI relating to specific individuals may be exchanged between Subcontractor and Contractor and between Subcontractor and OHA for purposes directly related to the provision of services to Members which are funded in whole or in part under the OHP Contract. However, Subcontractor shall not use or disclose any IIHI about specific individuals in a manner that would violate (i) the HIPAA Privacy Rules in CFR Parts 160 and 164; (ii) the OHA Privacy Rules, OAR 407-014-0000 et.seq., or (iii) the OHA Notice of Privacy Practices, if done by OHA. A copy of the most recent OHA Notice of Privacy Practices is posted on the OHA web site at: https://apps.state.or.us/cf1/FORMS/, Form number ME2090 Notice of Privacy Practices, or may be obtained from OHA.

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

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

d. Consultation and Testing. If Subcontractor reasonably believes that the Contractor's or OHA's data transactions system or other application of HIPAA privacy or security compliance policy may result in a violation of HIPAA requirements, Subcontractor shall promptly consult Contractor. Subcontractor agrees that Contractor or OHA may initiate a request for testing of HIPAA transaction requirements, subject to available resources and OHA testing schedule. (*OHP Contract Exhibit E, Section 6*)

26.7 Resource Conservation and Recovery. Subcontractor shall comply with all mandatory standards and policies that relate to resource conservation and recovery pursuant to the Resource Conservation and Recovery Act (codified at 42 USC 6901 et. seq.). Section 6002 of that Act (codified at 42 USC 6962) requires that preference be given in procurement programs to the purchase of specific products containing recycled materials identified in guidelines developed by the Environmental Protection Agency. Current guidelines are set forth in 40 CFR Part 247. (*OHP Contract Exhibit E, Section 7*)

26.8 Audits. Subcontractor shall comply with the applicable audit requirements and responsibilities set forth in the OHP Contract and applicable state or federal law and Office of Management and Budget Circular A-133 entitled "Audits of States, Local Governments and Non-Profit Organizations", as amended and supplemented, including by the December 2013 Uniform Administrative Requirements, Cost Principles and Audit Requirements for Federal Awards. (*OHP Contract Exhibit E, Section 8.a*)

26.9 Debarment and Suspension.

a. Subcontractor represents and warrants that it is not excluded by the U.S. Department of Health and Human Services Office of the Inspector General or listed on the non-procurement portion of the General Service Administration's "List of Parties Excluded from Federal Procurement or Nonprocurement Programs" in accordance with Executive Orders No. 12549 and No. 12689, "Debarment and Suspension." (See 2 CFR Part 180) If Subcontractor has awards that exceed the simplified acquisition threshold, Subcontractor shall provide the required certification regarding their exclusion status and that of their principals prior to award. (*OHP Contract Exhibit E, Section 9*)

b. Subcontractor acknowledges and agrees and shall ensure that no amounts are paid to a Provider that could be excluded from participation in Medicare or Medicaid for any of the following reasons: (i) the Provider is Controlled by a Sanctioned individual, (ii) the Provider has a contractual relationship that provides for the administration, management or provision of Medical Services, or the establishment of policies, or the provision of operational support for the administration, management or provision of Medical Services, either directly or indirectly, with an individual convicted of certain crimes as described in section 1128(b)(8)(B) of the Social Security Act, (iii) the Provider employs or contracts, directly or indirectly, for the furnishing of health care, Utilization Review, medical social work, or administrative services, with one of the following: (A) any individual or entity excluded from participation in federal health care programs or (B) any entity that would provide those services through an excluded individual or entity. Subcontractor is prohibited from knowingly having a person with ownership of 5% or more of the Subontractor's equity if such person is (or is affiliated with a person or entity that is) debarred, suspended, or excluded from participation in federal healthcare programs. (*OHP Contract Exhibit E, Section 9*)

c. Subcontractor shall not refer Members to or use Providers who have been terminated from OHA or excluded as Medicare, CHIP, or Medicaid Providers by CMS or who are subject to exclusion for any lawful conviction by a court for which the Provider could be excluded under 42 CFR §1001.101 and 42 CFR §455.3(b), and Subcontractor shall not employ or contract with Providers excluded from participation in Federal health care programs under 42 CFR §438.214(d). (*OHP Contract Exhibit B, Part 4, Section 6.g*)

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

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

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

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

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

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

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

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

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

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

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

26.11 Pro-Children Act. Subcontractor shall comply with the Pro-Children Act of 1994 (codified at 20 USC Section 6081 et. seq.). (*OHP Contract Exhibit E, Section 10*)

26.12 Clinical Laboratory Improvements. If Subcontractor is a laboratory, or contracts or uses any laboratories, Subcontractor shall comply and ensure compliance with the Clinical Laboratory Improvement Amendments (CLIA 1988), 42 CFR Part 493 Laboratory Requirements and ORS 438, which require that all Laboratory testing sites providing services under the 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. Laboratories with certificates of waiver will provide only the eight types of tests permitted under the terms of the waiver. Laboratories with certificates of registration may perform a full range of Laboratory tests. (*OHP Contract Exhibit E, Section 13*)

26.13 OASIS. To the extent applicable, Subcontractor shall comply with the Outcome and Assessment Information Set ("OASIS") reporting requirements and notice requirements for skilled services provided by Home Health Agencies, pursuant to the CMS requirements published in 42 CFR 484.20, and such subsequent regulations as CMS may issue in relation to the OASIS program. (*OHP Contract Exhibit E, Section 19*)

26.14 Patient Rights Condition of Participation. To the extent applicable, Subcontractor shall comply with the Patient Rights Condition of Participation that hospitals must meet to continue participation in the Oregon Health Plan program, pursuant to 42 CFR Part 482. For purposes of this Exhibit, hospitals include short-term, psychiatric, rehabilitation, long-term, and children's hospitals. (*OHP Contract Exhibit E, Section 20*)

26.15 Federal Grant Requirements. To the extent applicable to Subcontractor or to the extent OHA requires Contractor and its Subcontractors to supply information or comply with procedures to permit OHA to satisfy its obligations federal grant obligations or both, Subcontractor must comply with the following parts of 45 CFR: (a) Part 74, including Appendix A (uniform federal grant administration requirements); (b) Part 92 (uniform administrative requirements for grants to state, local and tribal governments); (c) Part 80 (nondiscrimination under Title VI of the Civil Rights Act); (d) Part 84 (nondiscrimination on the basis of handicap); (e) Part 91 (nondiscrimination on the basis of age); and (f) Part 95 (Medicaid and CHIP federal grant administration requirements). Subcontractor shall not expend any of the funds paid under the Agreement for roads, bridges, stadiums, or any other item or service not covered under the Oregon Health Plan ("OHP"). (*OHP Contract Exhibit E, Section 21*)

26.16 Title II of the Americans with Disabilities Act. Subcontractor shall 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. *(OHP Contract Exhibit B Part 4, Section 2.g and h.)*

27. **Marketing.** Subcontractor shall not initiate contact nor Market independently to potential Clients, directly or through any agent or independent contractor, in an attempt to influence an OHP Client's Enrollment with Contractor, without the express written consent of OHA. Subcontractor shall not conduct, directly, door-to-door, telephonic, mail, electronic, or other Cold Call Marketing practices to entice a Client to enroll with Contractor, or to not enroll with another OHP contractor. Subcontractor shall not seek to influence a Client's Enrollment with the Contractor in conjunction with the sale of any other insurance. Furthermore, Subcontractor understands that OHA must approve, prior to distribution, any written communication by Subcontractor that (a) is intended solely for Members, and (b) pertains to provider requirements for obtaining coordinated care services, care at service site or benefits. Notwithstanding anything to the contrary in this paragraph 27, Subcontractor may post a sign listing all OHP Coordinated Care Organizations to which Subcontractor belongs and display Coordinated Care Organization-sponsored health promotional materials. *(OHP Contract Exhibit B Part 3, Section13)*

28. **Workers' Compensation Coverage.** If Subcontractor employs subject workers, as defined in ORS 656.027, then Subcontractor shall comply with ORS 656.017 and shall provide workers' compensation insurance coverage for those workers, unless they meet the requirements for an exemption under ORS 656.126(2). (*OHP Contract Exhibit F, Section 1*)

29. **Third Party Resources.**

29.1 Provision of Covered Services. Subcontractor will ensure that the provision of Covered Services is not refused to a Member because of a potential Third Party Liability for payment for the Covered Services. (*OHP Contract Exhibit B, Part 8, Section 17.k*)

29.2 Reimbursement. Subcontractor agrees that where Medicare and Contractor have paid for services, and the amount available from the Third Party Payer is not sufficient to fully reimburse both programs for their respective claims, the Third Party Payer must first reimburse Medicare the full amount of its Claim before any other entity, including Subcontractor, may be paid. In addition, if a Third Party Payer has reimbursed Subcontractor, or if a Member, after receiving payment from a Third Party Payer, has reimbursed Subcontractor, then the parties who received such reimbursements must reimburse Medicare up to the full amount received from the Third Party Payer, if Medicare is unable to recover its payment from any remaining amounts payable by the Third Party Payer. (*OHP Contract Exhibit B, Part 8, Sections 17.s and 17.t*)

29.3 Confidentiality in Recovery Actions. When engaging in Third Party Liability recovery actions, Subcontractor shall comply with, and require agents to comply with, federal and State confidentiality requirements described in Exhibit E of the OHP Contract, and any other applicable additional confidentiality obligations required under the OHP Contract and state law. *OHP Contract Exhibit B, Part 8, Section 17.w*)

29.4 No Compensation. Except as permitted by the OHP Contract including Third Party Resources recovery, Subcontractor will not be compensated for Work performed under the OHP Contract from any other department of the State, nor from any other source including the federal government. (*OHP Contract Exhibit B Part 8, Section 4.c*)

29.5 Third Party Liability. Subcontractor shall maintain records of Subcontractor's actions related to Third Party Liability recovery, and make those records available for Contractor and OHA review. *(OHP Contract Exhibit B Part 8, Section 16.b.)*

29.6 Right of Recovery. Subcontractor shall comply with 42 USC 1395y(b) and 42 CFR Part 411, Subparts C-E, which gives Medicare the right to recover its benefits from employers and workers' compensation

carriers, liability insurers, automobile or no fault insurers, and employer group health plans before any other entity including Contractor or Subcontractor. (*OHP Contract Exhibit B, Part 8, Section 17.r*)

29.7 Disenrolled Members. If OHA retroactively Disenrolls a Member at the time the Member acquired the Other Primary Insurance, pursuant to OAR 410-141-3080(2)(b)(D) or 410-141-3080(3)(e)(A) or 410-141-3080(9)(a), Subcontractor may not, and will ensure that any of its subcontractors do not, seek to collect from a Member (or any financially responsible Member Representative) or any Third Party Payer, any amounts paid for any Covered Services provided on or after the date of Disenrollment. (*OHP Contract Exhibit B, Part 8, Section 17.q*)

29.8 Other Insurance. Subcontractor shall: (1) report to both Contractor and OHA any Other Insurance to which a Member may be entitled. Subcontractor must report such information to OHA and Contractor within thirty (30) days of becoming aware Member of such coverage. Reporting must be made online at the following URL: https://www.oregon.gov/DHS/BUSINESS-SERVICES/OPAR/Pages/tpl-hig.aspx; and (2) provide, in a timely manner upon request, OHA with all Third Party Liability eligibility information and any other information requested by OHA, in order to assist in the pursuit of financial recovery. (*OHP Contract Exhibit B, Part 8, Section 16.m*)

30. **Preventive Care.**Where Preventive Care Services are provided by or through Subcontractor (including, but not limited to, FQHCs, Rural Health Clinics and County Health Departments), all Preventive Care Services provided to Members will be reported to Contractor and are subject to Contractor's Medical Case Management and Record Keeping responsibilities. (*OHP Contract Exhibit B, Part 2, Section 6.a(3)*

31. **Accessibility.**

31.1 Timely Access, Hours. Subcontractor shall meet OHP standards for timely access to care and services, taking into account the urgency of the need for services as specified in OAR 410-141-3220 and 410-141-3160. Covered Services will be made available twenty-four (24) hours a day, seven (7) days a week, when Medically Appropriate. This requirement includes the offering of hours of operation to Members that are not less than the hours of operation offered to commercial members (as applicable) and non-Members as provided in OAR 410-141-3220. (*OHP Contract Exhibit B, Part 4, Sections 2.a, 2.c and 12.b(1)(m)*)

31.2 Special Needs. Subcontractor and Subcontractor's facilities shall meet the special needs of Members who require accommodations because of a disability or limited English proficiency. (*OHP Contract Exhibit B, Part 4, Sections 2.i*)

31.3 Facilities. Subcontractor and Subcontractor's facilities shall be culturally responsive and linguistically appropriate to satisfy the diverse needs of Members, including, without limitation, adolescents, parents with dependent children, pregnant women, IV drug users and those with medication assisted therapy needs. (*OHP Contract Exhibit B, Part 4, Section 3.a(7)*)

32. **Member Rights.**

32.1 Treating Members with Respect and Equality. Subcontractor shall treat each Member with respect and with due consideration for his or her dignity and privacy. In addition, Subcontractor shall treat each Member the same as non-Members or other patients who receive services equivalent to Covered Services. (*OHP Contract Exhibit B, Part 3, Section 2.n*)

32.2 Information on Treatment Options. Subcontractor shall ensure that each Member receives information on available treatment options and alternatives in a manner appropriate to the Member's condition and ability to understand. (*OHP Contract Exhibit B, Part 3, Section 2.h*)

32.3 Participation Decisions. Subcontractor shall allow each Member to: (a) be actively involved in the development of Treatment Plans if Covered Services are to be provided, (b) participate in decisions regarding his or her own health care, including the right to refuse treatment, (c) accept or refuse medical, surgical, or Behavioral Health treatment, (d) execute directives and powers of attorney for health care established under ORS 127.505 to

127.660 and the Omnibus Budget Reconciliation Act of 1990 -- Patient Self-Determination Act, and (e) have Family involved in such Treatment Planning. (*OHP Contract Exhibit B, Part 3, Section 2.i*)

32.4 Copy of Medical Records. Subcontractor shall ensure that each Member may request and receive a copy of his or her own Health Record (unless access is restricted in accordance with ORS 19.505 or other Applicable Law) and to request that the records be amended or corrected as specified in 45 CFR Part 164. (*OHP Contract Exhibit B Part 3, Section 2.j*)

32.5 Exercise of Rights. Subcontractor shall ensure that each Member is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the Contractor, its staff, Subcontractor, Participating Providers, or OHA treat the Member. (*OHP Contract Exhibit B, Part 3, Section 2.o*)

33. **Grievance System.** Subcontractor shall comply with the Grievance and Appeal System requirements set forth in Exhibit I, and any other applicable provisions, of the OHP Contract. Subcontractor shall promptly cooperate with the investigations and resolution of a Grievance by either or both DHS' Client Services Unit and OHA's Ombudsperson as expeditiously as the affected Member's health condition requires, and within timeframes set forth in or required by the OHP Contract. Subcontractor shall cooperate with DHS's Governor's Advocacy Office, the OHA Ombudsman and hearing representatives in all of the OHA's activities related to Members' grievances, appeals and hearings including providing all requested written materials. (*OHP Contract Exhibit I, Sections 1.b(1), 2.d*)

34. **Authorization of Service.** Subcontractor shall follow Contractor's policies and procedures, including those in its Service Authorization Handbook, in order to obtain initial and continuing Service Authorizations. In addition, Subcontractor must adhere to the policies and procedures set forth in the Service Authorization Handbook. (*OHP Contract Exhibit B Part 2, Section 3.a*)

35. **Non-Discrimination.**

35.1 Subcontractor shall not discriminate between Members and non-OHP persons as it relates to benefits and services to which they are both entitled. (*OHP Contract Exhibit B, Part 4, Section 2.c*)

35.2 Subcontractor shall 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. (*OHP Contract Exhibit E, Section 18*)

36. **Record Keeping System.** Subcontractor shall develop and maintain a record keeping system that: (a) includes sufficient detail and clarity to permit internal and external review to validate Encounter Data submissions and to assure Members have been, and are being, provided with Medically Appropriate services consistent with the documented needs of the Member; (b) conforms to accepted professional practice and any and all Applicable Laws related thereto; and (c) is supported by written policies and procedures; and (d) allows the Subcontractor to ensure that data submitted to it or Contractor is accurate and complete by: (i) verifying the accuracy and timeliness of reported data; (ii) screening the data for completeness, logic, and consistency; and (iii) collecting service information in standardized formats. (*OHP Contract Exhibit B Part 8, Section 1.e*)

37. **Enrollment; Unique Provider Identification Number.** Subcontractor shall have, or shall confirm that each Physician or other qualified provider is enrolled with CMS and OHA and has a unique provider identification number that complies with 42 USC 1320d-2(b). (*OHP Contract Exhibit B Part 4, Section 6.j*)

38. **Accreditation.** If Subcontractor is not, or contracts with a Provider that is not, required to be licensed or certificated by the State of Oregon board or licensing agency, the Subcontractor or Provider, as applicable, must either (a) meet the definitions for Qualified Mental Health Associate (QMHA) or Qualified Mental Health Professional (QMHP) and must not be permitted to provide services without the supervision of a Licensed Medical Practitioner; or (b) if not meeting either the definitions of a QMHP or QMHA have the education, experience,

competence necessary to perform the specified assigned duties and provide such information to Contractor, so that Contractor may document and report to OHA in its DSN Provider Report: (i) the education, experience and competence of such Participating Provider, and (ii) that such Participating Provider will not be permitted to permitted to perform the specific assigned duties without the supervision of a Licensed Medical Practitioner. If programs or facilities of Subcontractor are not required to be licensed or certified by the State of Oregon board or licensing agency, Subcontractor will provide documentation that demonstrates accreditation by nationally recognized organizations recognized by OHA for the services provided (e.g., Council on Accredited Rehabilitation Facilities, The Joint Commission). (*OHP Contract Exhibit B Part 4, Section 6.d*)

39. **Advocacy.** Except as provided in the OHP Contract, Subcontractor shall not prohibit or otherwise limit or restrict Health Care Professionals or subcontractors acting within the lawful scope of practice, from undertaking any of the following activities set forth in this Section on behalf of a Member: (a) advising or otherwise advocating for the Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered, that is Medically Appropriate even if such care or treatment is not covered under the OHP Contract or is subject to Copayment; (b) providing any and all information the Member needs in order to decide among relevant treatment options; (c) advising a Member of the risks, benefits, and consequences of treatment or non-treatment; and (d) advising and advocating for the Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions. (*OHP Contract Exhibit B Part 2, Section 3.b.(15)*)

40. **Health Information Technology.** Subcontractor shall (a) be registered with a statewide or local Direct-enabled Health Information Service Provider, or (b) be a member of an existing Health Information Organization with the ability for providers on any electronic health record system (or with no electronic health record system) to be able to share electronic information with any other provider within the Contractor's network. *(OHP Contract Exhibit B Part 4, Section 7; and Exhibit J, Section 1)*

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

42. **Notice of Termination.** Subcontractor acknowledges and agrees that, if required under the OHP Contract, Contractor will be the party responsible for providing written notice of the termination of the Agreement to each Member who received primary care from, or was seen on a regular basis by, the Subcontractor. (*OHP Contract Exhibit B, Part 4, Section 12.b(2)*)

43. **Patient Centered Primary Care Homes.** Subcontractor shall ensure communication and coordination of care with the patient-centered primary care homes ("PCPCH") in a timely manner using electronic health information technology to the maximum extent feasible. (*OHP Contract Exhibit B, Part 4, Section 7.c*)

44. **Care Integration.** If Subcontractor contracts with Participating Providers that are specialty or Hospital Providers, Subcontractor will ensure that its agreement with each such Participating Provider: (i) addresses the coordinating role of patient-centered primary care; (ii) specifies processes for requesting Hospital admission or specialty services; and (iii) establishes performance expectations for communication and medical records sharing for specialty treatments: (x) at the time of Hospital admission or (y) at the time of Hospital discharge for the purpose of facilitating after-Hospital follow up appointments and care. (*OHP Contract Exhibit B, Part 4, Section 9.a(3)*)

45. **Oregon House Bill 2398.** Consistent with 42 CFR § 438.106 and 42 CFR § 438.230, Subcontractor is prohibited, and will prohibit its Providers, from billing Members for Covered Services in any amount greater than would be owed if Contractor provided the services directly. Subcontractors shall comply with Oregon House Bill 2398 (Engrossed) 2017 which requires Providers to: (1) wait ninety (90) days after submitting the claim before assigning a claim to a collection agency or other similar entity for the purpose of recovering fees from the patient; (2) query OHA's database to confirm eligibility for medical assistance; (3) assign any outstanding claims to a

collection agency or other similar entity for the purpose of recovering fees from a patient ***only if***, at the time of service, the patient was not eligible for medical assistance. (*OHP Contract Exhibit B, Part 8, Section 4.f*)

46. **Survival.** All rights and obligations cease upon termination or expiration of the Agreement or OHP Contract, except for the rights and obligations, and declarations which expressly or by their nature survive termination of the Agreement or OHP Contract. Without limiting the foregoing or anything else in the OHP Contract, in no event shall contract expiration or termination extinguish or prejudice OHA's or Contractor's right to enforce the OHP Contract or the Agreement with respect to any default by Subcontractor that has not been cured. In addition to any other provisions of the OHP Contract or the Agreement that by their context are meant to survive contract expiration or termination, the special terms and conditions specified in Section 25.f of Exhibit D of the OHP Contract survive OHP Contract expiration or termination for a period of two (2) years unless a longer period is set forth in the OHP Contract. (*OHP Contract Exhibit D, Sections 20 and 25*)

47. **Equal Access.** Subcontractor shall provide equal access to Covered Services for both male and female Members under 18 years of age, including access to appropriate facilities, services and treatment, to achieve the policy in ORS 417.270. (*OHP Contract Exhibit D, Sections 20 and 31*)

48. **Media Disclosure.** Subcontractor shall not provide information to the media regarding a recipient of services under the OHP Contract without first consulting with and receiving approval from the OHA and Contractor. Subcontractor shall make immediate contact with Contractor, and Contractor will manage contacts with the OHA office when media contact occurs. The OHA office will assist the Contractor with an appropriate follow-up response for the media. (*OHP Contract Exhibit D, Sections 20 and 32*)

49. **Mandatory Reporting of Abuse.** Subcontractor shall immediately report any evidence of Child Abuse, neglect or threat of harm to DHS Child Protective Services or law enforcement officials in full accordance with the mandatory Child Abuse Reporting law (ORS 419B.005 to 419B.045). If law enforcement is notified, Subcontractor shall notify the referring caseworker within 24 hours. Subcontractor shall immediately contact the local DHS Child Protective Services office if questions arise whether an incident meets the definition of Child Abuse or neglect. Subcontractor shall comply with all protective services, investigation and reporting requirements described in any of the following laws: (1) OAR 407-045-0000 through 407-045-0370 (abuse investigations by the Office of Investigations and Training); (2) ORS 430.735 through 430.765 (persons with mental illness or developmental disabilities); (3) ORS 124.005 to 124.040 (elderly persons and persons with disabilities abuse); and **(4)** ORS 441.650 to 441.680 (residents of long term care facilities). (*OHP Contract Exhibit D, Sections 20 and 33*)

50. **Behavioral Health Screening; Reporting.** Subcontractor will: (a) Screen Members for adequacy of supports for the Family in the home (e.g., housing adequacy, nutrition/food, diaper needs, Transportation needs, safety needs and home visiting); (b) Screen Members for, and provide, Medically Appropriate and Evidence-Based treatments for Members who have both mental illness and Substance Use Disorders; (c) assess for opioid use disorders for populations at high risk for severe health outcomes, including overdose and death, including pregnant Members and Members being discharged from residential, Acute Care, and other institutional settings; and (d) Screen Members and provide prevention, early detection, brief intervention and Referral to Behavioral Health services in any of the following circumstances: (i) at an initial contact or during a routine physical exam; (ii) at an initial prenatal exam; (iii) when the Member shows evidence of Substance Use Disorders or abuse; (iv) when the Member over-utilizes Covered Services; and (v) when a Member exhibits a reassessment trigger for Intensive Care Coordination needs. Subcontractor will supply all required information to support the Behavioral Health reporting process described in Exhibit M of the OHP Contract. In developing Individual Service and Support Plans for Members, Subcontractor will assess for Adverse Childhood Experiences (ACE), trauma and resiliency in a Culturally and Linguistically Appropriate manner, using a Trauma Informed framework. (*OHP Contract Exhibit M, Sections 6, 20.g and 21.c*).

51. **Provider Directories.** Subcontractor will adhere to Contractor's established policies for Provider Directories and the applicable timeframes for updating the information therein. (*OHP Contract Exhibit B Part 3, Section 6.i*)

52. **Provider Workforce Development.** Subcontractor and Subcontractor's staff shall participate in trainings on Cultural Responsiveness and implicit bias as set forth in Exhibit K, Section 10.d. of the OHP Contract as may be

arranged by Contractor. Moreover, Subcontractor shall comply with all reporting requirements described in or required by Exhibit K, Section 10.d *(OHP Contract, Exhibit B Part 4, Section 4.b.(10))*

53. **Business Associate Agreement.** Subcontractor will enter into such Business Associate Agreements with Contractor when required by HIPAA. *(OHP Contract, Exhibit B Part 4, Section 12.a.(3))*

54. **Behavioral Health Training.** Subcontractor shall participate in trainings relating to integration, and Foundations of Trauma Informed Care, and recovery principles, and motivational interviewing, as set forth and described in Exhibit M, Section 21 of the OHP Contract as may be arranged by Contractor. *(OHP Contract, Exhibit M, Section 21)*.

55. **Cooperation with Contractor's NAIC Financial Reporting.** Subcontractor shall promptly and truthfully respond to all inquiries made by OHA or by DCBS on behalf of OHA concerning the Work and transactions contemplated by the OHP Contract, together with any other matter presented under or in connection with the OHP Contract, using the form of communication requested by OHA or CDBS, as applicable. *(OHP Contract, Exhibit L, Section 2.a.(2))*

Attachment A: Medicaid

EXHIBIT 1
COMPENSATION SCHEDULE
PROFESSIONAL SERVICES

County of Clackamas, Oregon

This compensation schedule ("Compensation Schedule") sets forth the maximum reimbursement amounts for Covered Services provided by Contracted Providers to Covered Persons enrolled in a Medicaid Product. Where the Contracted Provider's tax identification number ("TIN") has been designated by the Payor as subject to this Compensation Schedule, Payor shall pay or arrange for payment of a Clean Claim for Covered Services rendered by the Contracted Provider according to the terms of, and subject to the requirements set forth in, the Agreement and this Compensation Schedule. Payment under this Compensation Schedule shall consist of the Allowed Amount as set forth herein less all applicable Cost-Sharing Amounts. All capitalized terms used in this Compensation Schedule shall have the meanings set forth in the Agreement, the applicable Product Attachment, or the Definitions section set forth at the end of this Compensation Schedule.

The maximum compensation for professional Covered Services rendered to a Covered Person shall be the "Allowed Amount." Except as otherwise provided in this Compensation Schedule, the Allowed Amount for professional Covered Services is the "Contracted Rate" percentage by provider type Service Category as set forth below in Table 1.

Table 1

Service Category	Contracted Rate
Professional Services includes OB and Anesthesia Services	125% of the Oregon Health Plan DMAP fee schedule
Other Professional Services HCPCS	125% of the Oregon Health Plan DMAP fee schedule
DME	100% of the Oregon Health Plan DMAP fee schedule
Laboratory Services	Laboratory services should be directed to an In Network Specialty Lab. Reimbursement for Stat Lab service codes identified on the Trillium Community Health Plan website shall be limited to these codes or its successors that are payable by Oregon Health Plan and allowed at 100% of DMAP fee schedule.

Additional Provisions:

1. Code Change Updates. Payor utilizes nationally recognized coding structures (including, without limitation, revenue codes, CPT codes, HCPCS codes, ICD codes, national drug codes, ASA relative values, etc., or their successors) for basic coding and descriptions of the services rendered. Updates to billing-related codes shall become effective on the date ("Code Change Effective Date") that is the later of: (i) the first day of the month following sixty (60) days after publication by the governmental agency having authority over the applicable Product of such governmental agency's acceptance of such code updates, (ii) the effective date of such code updates as determined by such governmental agency or (iii) if a date is not established by such governmental agency or the applicable Product is not regulated by such governmental agency, the date that changes are made to nationally recognized codes. Such updates may include changes to service groupings. Claims processed prior to the Code Change Effective Date shall not be reprocessed to reflect any such code updates.

2. Fee Change Updates. Updates to the fee schedule shall become effective on the effective date of such fee schedule updates, as determined by the Payor ("Fee Change Effective Date"). The date of implementation of any fee schedule updates, i.e. the date on which such fee change is first used for reimbursement ("Fee Change Implementation Date"), shall be the later of: (i) the first date on which Payor is reasonably able to implement the

update in the claims payment system; or (ii) the Fee Change Effective Date. Claims processed prior to the Fee Change Implementation Date shall not be reprocessed to reflect any updates to such fee schedule, even if service was provided after the Fee Change Effective Date.

3. Fee Sources. In the event CMS contains no published fee amount, alternate (or "gap fill") fee sources may be used to supply the fee basis amount for deriving fee amount (the "Alternative Fee Source Amount"). Health Plan will utilize such Alternative Fee Source Amount until such time that CMS publishes its own resource-based relative value scale (RBRVS) value. At such time in the future as CMS publishes its own RBRVS value for that CPT/HCPCS code, Payor will use the CMS fee amount for that code and no longer use the Alternate Fee Source Amount. If CMS has no published fee amount or a gap fill fee source is not available for a Covered Service provided to a Covered Person, Payor may establish a payment amount to apply in determining the Allowed Amount. Until such time as Payor establishes such a payment amount, the maximum compensation shall be 51% of Allowable Charges

4. Modifier. Unless specifically indicated otherwise, fee amounts listed in the fee schedule represent global fees and may be subject to reductions based on appropriate Modifier (for example, professional and technical modifiers). As used in the previous sentence, "global fees" refers to services billed without a Modifier, for which the fee amount includes both the professional component and the technical component. Any Cost-Sharing Amounts that the Covered Person is responsible to pay under the Coverage Agreement will be subtracted from the Allowed Amount in determining the amount to be paid.

5. Anesthesia Modifier Pricing Rules. The dollar amount that will be used in the calculation of time-based and non-time based anesthesia management fees in accordance with the anesthesia payment policy. Unless specifically stated otherwise, the anesthesia conversion factor indicated is fixed and will not change. The anesthesia conversion factor is based on an anesthesia time unit value of 15 minutes.

6. Place of Service Pricing Rules. This fee schedule follows CMS guidelines for determining when services are priced at the facility or non-facility fee schedule (with the exception of services performed at ambulatory surgery centers, POS 24, which will be priced at the facility fee schedule).

7. Carve-Out Services. With respect to any "Carve-Out" Covered Services as contemplated in this Agreement, any payment arrangement entered into between Provider and a third party vendor of such services shall supersede compensation hereunder.

8. Payment under this Compensation Schedule. Claims should be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative (CCI) Policy Manual, CCI table edits and other CMS guidelines). All payments under this Compensation Schedule are subject to the terms and conditions set forth in the Agreement, the Provider Manual, and any applicable billing manual and claims processing policies.

Definitions:

1. **Allowed Amount** means the amount designated in this Compensation Schedule as the maximum amount payable to a Contracted Provider for any particular Covered Service provided to any particular Covered Person, pursuant to this Agreement or its Attachments.

2. **Allowable Charges** means a Contracted Provider's billed charges for services that qualify as Covered Services.

3. **Cost-Sharing Amounts** means any amounts payable by a Covered Person, such as copayments, cost-sharing, coinsurance, deductibles or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement, if applicable.

Attachment A: Medicaid

EXHIBIT 2
COMPENSATION SCHEDULE
PRACTITIONER SERVICES
BEHAVIORAL HEALTH

County of Clackamas, Oregon

This compensation schedule ("Compensation Schedule") sets forth the maximum reimbursement amounts for Covered Services provided by Contracted Providers to Covered Persons enrolled in a Medicaid Product. Where the Contracted Provider's tax identification number ("TIN") has been designated by the Payor as subject to this Compensation Schedule, Payor shall pay or arrange for payment of a Clean Claim for Covered Services rendered by the Contracted Provider according to the terms of, and subject to the requirements set forth in, the Agreement and this Compensation Schedule. Payment under this Compensation Schedule shall consist of the Allowed Amount as set forth herein less all applicable Cost-Sharing Amounts. All capitalized terms used in this Compensation Schedule shall have the meanings set forth in the Agreement, the applicable Product Attachment, or the Definitions section set forth at the end of this Compensation Schedule.

The maximum compensation for behavioral health Covered Services rendered to a Covered Person shall be the "Allowed Amount." Except as otherwise provided in this Compensation Schedule, the Allowed Amount for behavioral health Covered Services is the "Contracted Rate" percentage for the provider type as set forth below in Table 1.

Table 1.

Service Category	**Contracted Rate**		
	Prescribers: **MD**, **DO**, **NP**, **PA**	**Licensed**: Includes **PhD**, **PsyD**, **LCSW**, **LPC**, **LMFT** or other licensed practitioner determined by OHA to be payable.	**Non-Licensed**: Includes **MSW**, **QMHP Intern**, **QMHA**, **Peer Support** or other non-licensed practitioner determined by OHA to be payable.
Professional Services	135% of the Payor's Oregon Health Plan DMAP fee schedule	125% of the Payor's Oregon Health Plan DMAP fee schedule	115% of the Payor's Oregon Health Plan DMAP fee schedule
HCPCS	135% of the Payor's Oregon Health Plan DMAP fee schedule	125% of the Payor's Oregon Health Plan DMAP fee schedule	115% of the Payor's Oregon Health Plan DMAP fee schedule
Laboratory Services	Laboratory services should be directed to an in-network specialty lab. 100% of DMAP fee schedule		

Fee Schedule Note: For the behavioral health services outlined in Table 1, this agreement covers all ages and outpatient behavioral health programs offered by the provider.

Additional Provisions:

1. Code Change Updates. Payor utilizes nationally recognized coding structures (including, without limitation, revenue codes, CPT codes, HCPCS codes, ICD codes, national drug codes, ASA relative values, etc., or their successors) for basic coding and descriptions of the services rendered. Updates to billing-related codes shall become effective on the date ("Code Change Effective Date") that is the later of: (i) the first day of the month following 60 days after publication by the governmental agency having authority over the applicable Product of such governmental agency's acceptance of such code updates, (ii) the effective date of such code updates as determined by such governmental agency or (iii) if a date is not established by such governmental agency or the applicable Product is not regulated by such governmental agency, the date that changes are made to nationally

recognized codes. Such updates may include changes to service groupings. Claims processed prior to the Code Change Effective Date shall not be reprocessed to reflect any such code updates.

2. Fee Change Updates. Updates to the fee schedule shall become effective on the effective date of such fee schedule updates, as determined by Payor ("Fee Change Effective Date"). The date of implementation of any fee schedule updates, i.e. the date on which such fee change is first used for reimbursement ("Fee Change Implementation Date"), shall be the later of: (i) 60 days of being published in a final rule and becoming reasonably available to Payor; or (ii) the Fee Change Effective Date. Claims processed prior to the Fee Change Implementation Date shall not be reprocessed to reflect any updates to such fee schedule, even if service was provided after the Fee Change Effective Date.

3. Fee Sources. In the event CMS contains no published fee amount, alternate (or "gap fill") fee sources may be used to supply the fee basis amount for deriving fee amount (the "Alternative Fee Source Amount"). Payor will utilize such Alternative Fee Source Amount until such time that CMS publishes its own resource-based relative value scale (RBRVS) value. At such time in the future as CMS publishes its own RBRVS value for that CPT/HCPCS code, Payor will use the CMS fee amount for that code and no longer use the Alternate Fee Source Amount. If there is no established payment amount on the current Medicare fee schedule or a gap fill fee source is not available for a Covered Service provided to a Covered Person, Payor may establish a payment amount to apply in determining the Allowed Amount. Until such time as Payor establishes such a payment amount, the maximum compensation shall be 25% of Allowable Charges.

4. Modifier. Unless specifically indicated otherwise, fee amounts listed in the fee schedule represent global fees and may be subject to reductions based on appropriate Modifier (for example, professional and technical modifiers). As used in the previous sentence, "global fees" refers to services billed without a Modifier, for which the fee amount includes both the professional component and the technical component. Any Cost-Sharing Amounts that the Covered Person is responsible to pay under the Coverage Agreement will be subtracted from the Allowed Amount in determining the amount to be paid.

Definitions:

1. **Allowed Amount** means the amount designated in this Compensation Schedule as the maximum amount payable to a Contracted Provider for any particular Covered Service provided to any particular Covered Person, pursuant to this Agreement or its Attachments.

2. **Allowable Charges** means a Contracted Provider's billed charges for services that qualify as Covered Services.

3. **Cost-Sharing Amounts** means any amounts payable by a Covered Person, such as copayments, cost-sharing, coinsurance, deductibles or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement, if applicable.

4. **DMAP** – means Division of Medical Assistance Programs.

Attachment A: Medicaid

PATIENT CENTERED PRIMARY CARE HOME (PCPCH) SERVICES INCENTIVE PLAN

PCPCH INCENTIVE PLAN DESCRIPTION

I. Purpose

The Parties seek to support the Patient Centered Primary Care Home (PCPCH) Alternative Payment Methodologies (APM) for the following purposes: (i) to enable Provider and its Contracted Providers support of the Patient Centered Primary Care Home (PCPCH) programs with a focus on behavioral health integration, and (ii) to enable Company and Provider and its Contracted Providers to demonstrate improved health outcomes for Covered Persons thereby lowering overall health care costs. The Parties believe that care coordination as supported through PCPCH is integral to better health outcomes and patient satisfaction.

Recognition for PCPCH provider status requires a commitment to providing high quality, patient-centered, comprehensive, and team-based care. Company has recognized the investment necessary to achieve the very high standards required of a Tier 1, Tier 2, Tier 3, Tier 4, and Tier 5 PCPCH. With that recognition, Company offers an alternative payment methodology to invest in those clinics who have achieved such recognition. The goal of the PCPCH program will be to continue support of the integrated services which have helped Providers and its Contracted Provides achieve a high standard of recognition and sponsor provider innovation which supports the Triple Aim.

The PCPCH Program will support Provider's and its Contracted Providers Treatment, Payment and/or Health Care Operations functions by: (i) providing Provider and its Contracted Providers necessary Covered Person utilization data; (ii) enhancing Provider's and its Contracted Providers ability to better coordinate treatment plans as well as the Covered Persons participation in those plans; and (iii) providing a financial incentive to Providers and its Contracted Providers to invest in non-compensated care necessary to the evolution of payment reform. By sharing relevant, timely data with Provider, Provider and its Contracted Providers will be better able to ensure that appropriate follow-up communication and care is conducted with the Covered Person, and related treatment plans are better coordinated amongst the various entities involved in the treatment plan. The heightened attention provided through the Program will help realize the mutual goal of improved quality and health outcomes for Covered Persons and more effective use of health care resources.

Eligible Covered Persons are defined as Company Covered Persons who are eligible to be counted in the Measure denominator based of age, medical history, and other criteria as set forth by the Oregon Health Authority.

II. Method for Alternative Payment

Company shall make monthly case management payments to Provider based on the number of enrollees eligible and assigned by Company to receive a per member per month payment (PMPM) of:

PCPCH Tier	PMPM
1	$0.25
2	$0.50
3	$1.00
4	$4.00
5	$6.00

Should Provider and its Contracted Providers attain a higher level of recognition or lose a level of recognition as a PCPCH Provider and its Contracted Providers during the term of this agreement, the PMPM will reflect the change in PCPCH tier in the first full month following newly recognized. Identification of practice sites meeting PCPCH criteria

will be identified from the OHA website (http://www.oregon.gov/OHA/HPA/CSI-PCPCH/Pages/Recognition-Oregon-Payers.aspx). Site will be reviewed by Company at the beginning of each calendar quarter in order to confirm PCPCH tier status. PCPCH PMPM payments may be adjusted retroactively based on effective dates identified by OHA.

Construction. Except as expressly provided herein, the terms and conditions of the Agreement will remain unchanged and in full force and effect. In the event of a conflict between the provisions of the Agreement and the provisions of this Attachment, this Attachment will govern with respect to health care services, supplies or accommodations (including Covered Services) rendered to Covered Persons enrolled in the Medicaid Product. To the extent Provider or any Contracted Provider is unclear about its, his or her respective duties and obligations, Provider or the applicable Contracted Provider shall request clarification from the Company.

Term. This Attachment will become effective as of the Effective Date, and will be coterminous with the Agreement unless a party or a Contracted Provider terminates the participation of the Contracted Provider in the Medicaid Product in accordance with the applicable provisions of the Agreement or this Attachment.