Health, Housing & Human Services
CLACKAMAS COUNTY

Mary Rumbaugh
Director

February 13, 2025

BCC Agenda Date/Item: _____

Board of County Commissioners
Clackamas County

Approval of a Behavioral Health Services Agreement with Trillium Community Health Plan for behavioral health services, care coordination, peer and mobile crisis intervention, and provider oversight. Agreement Value is $856,139.30 for 2 years. Funding is through the Oregon Health Plan. No County General Funds are involved.

Previous Board Action/Review	No previous board action.		
Performance Clackamas	Ensuring safe, healthy, and secure communities through the provision of mental health and substance use services.		
Counsel Review	Yes	**Procurement Review**	No
Contact Person	Elise Thompson	**Contact Phone**	503-742-5353

EXECUTIVE SUMMARY: The Behavioral Health Division (BHD) of the Health, Housing, and Human Services Department requests the approval of a revenue agreement with Trillium Community Health Plan, Inc. (Trillium) for the funding of certain behavioral health services. This Agreement provides the funds for Behavioral Health Mobile Crisis, Choice Care Coordination, Wraparound Care Coordination and Peer Services, and administrative support to ensure compliance with the Agreement.

As one of the region's Coordinated Care Organizations (CCOs), Trillium is obligated under the terms of its contract with the Oregon Health Authority (OHA) to coordinate its services with local mental health and public health authorities in its service area. BHD assists Trillium in achieving its performance-based incentive metrics. The revenue received by BHD is based on the number of plan members and established service rates.

In 2024, Clackamas County averaged 8,519 Trillium Community Health Plan members.

This Agreement, with a maximum value of $856,139.30, is effective January 1, 2024, and continues through December 31, 2025.

RECOMMENDATION: Staff respectfully requests that the Board of Commissioners approve this Agreement (11767) and authorize Chair Roberts to sign on behalf of Clackamas County.

Respectfully submitted,

Mary Rumbaugh

Mary Rumbaugh
Director of Health, Housing and Human Services

For Filing Use Only

THIS ADMINISTRATIVE SERVICES AGREEMENT (together with all Attachments, Exhibits, Addendums, and Amendments, this "**Agreement**") is entered by and between Clackamas County, Oregon, a municipal corporation ("**County**" or "**Vendor**" or "**Provider**"), duly licensed and operating in accordance with the laws of the State, and Trillium Community Health Plan, Inc. ("**Trillium**" or "**Health Plan**"), (each a "**Party**" and collectively the "**Parties**"), effective January 1, 2024 (the "**Effective Date**").

RECITALS

A. WHEREAS, Trillium is a Coordinated Care Organization ("**CCO**") that has entered into a contract ("**CCO Contract**") with the Oregon Health Authority ("**OHA**") to arrange for the provision of managed care services under the Oregon Health Plan's CCO 2.0 Program ("**OHP Program**") for enrollees in the Oregon Health Plan ("**OHP**") who have selected or been assigned to Trillium ("**Trillium Members**", **"Members"** or **"Covered Persons"**).

B. WHEREAS, the County is a political subdivision of the State of Oregon, operates an array of human services and community health functions for Clackamas County, has established expertise and capability to administer Behavioral Health Services under County's role as the Local Mental Health Authority ("**LMHA**"), Community Mental Health Program ("**CMHP**"), Community Developmental Disabilities Program ("**CDDP**"), Local Public Health Authority ("**LPHA**"), and services for Children, Youth and Families, and is operating in accordance with all applicable State and federal laws and regulations.

C. WHEREAS, the County is an organization engaged in the business of providing the administrative services described in this Agreement;

D. WHEREAS, the County also desires to provide certain health care services to individuals in products offered by or available from or through Health Plan, and County desires to participate in such products as a Participating Provider (as defined herein), all as hereinafter set forth.

E. WHEREAS, Trillium desires to engage the County to provide such administrative and certain health care services; and the County is willing to provide such services under the terms and conditions set forth herein.

NOW, THEREFORE, in consideration of the recitals and mutual promises herein stated, the Parties hereby agree to the provisions set forth below it is agreed as follows:

DEFINITIONS

1. 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.

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 4 or Section 28.10, all of which are incorporated herein by reference and may be amended from time to time as provided in this Agreement.

1.3. "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.

1.4. "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.

1.5. "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.

1.6. "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.

1.7. "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".

1.8. "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.

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

1.10. "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.

1.11. "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.

1.12. "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.

1.13. "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).

1.14. "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.

1.15. "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.

1.16. "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.

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

SERVICES

2. Description of Services. Vendor shall perform the administrative and health care services ("Services") and provide the items to be delivered to Health Plan ("Deliverables") as described in Exhibit A, Scope of Services. Health Plan agrees to delegate to Vendor the responsibility to perform certain administrative services provided by Vendor pursuant to this Agreement, subject to the continuing oversight of Health Plan. The terms of this delegation, including a description of the Administrative Services to be provided by Vendor, are set forth in the Delegated Services Agreement attached to this Agreement as Exhibit B. Vendor shall provide, and cause its Contracted Providers to provide, Services in a manner that is consistent with the terms of this Agreement, the recognized standard of care for the provision of Services, and applicable federal, state and local law.

3. Contracted Providers. Vendor 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 Vendor and Contracted Providers under this Agreement (including each Attachment), and the Provider Manual.

4. 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 4 hereof.

   4.1. Vendor 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 4 hereof.

   4.2. 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. Vendor 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.

   4.3. Vendor 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. Vendor 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. Vendor shall provide such lists in a manner and format mutually acceptable to the Parties.

   4.4. Vendor may add new providers to this Agreement as Contracted Providers. In such case, Vendor 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. Vendor shall maintain policies and procedures for each of its employed Contracted Providers and written agreements with each of its subcontracted Contracted Providers (other than Vendor) that require the Contracted Providers to comply with Regulatory Requirements and the terms and conditions of this Agreement that apply to Contracted Providers.

   4.5. 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 Vendor, 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 Vendor 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 Vendor timely provides such opt-out notice, the applicable Contracted Providers will not be considered Participating Providers in such Product. If Vendor 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.

5. 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.

6. Provider Manual; Policies and Procedures. Vendor 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 Vendor 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 Vendor and Contracted Providers via one or more designated websites or alternative means. Upon Vendor's reasonable request, Health Plan shall provide Vendor 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 Vendor 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).

7. Credentialing Criteria. Vendor 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. Vendor 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.

8. Eligibility Determinations. Vendor 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.

9. Referral and Preauthorization Procedures. Vendor 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, Vendor 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 Vendor and Contracted Providers to follow such procedures may result in denial of payment for unauthorized treatment.

10. 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. Vendor 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.

11. Carve-Out Vendors. Vendor 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. Vendor 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.

12. Disparagement Prohibition. Vendor, 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 Vendor 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, Vendor or a Contracted Provider to inform Covered Persons that this Agreement has been terminated or otherwise expired or, with respect to Vendor, to promote Vendor to the general public or to post information regarding other health plans consistent with Vendor'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 Vendor 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.

13. Notice of Certain Events. Vendor 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 Vendor's or a Contracted Provider's license; (iii) termination, suspension, exclusion or voluntary withdrawal of Vendor 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 Vendor or a Contracted Provider alleging professional malpractice involving a Covered Person. In any instance described in subsection (i)-(iii) above, Vendor must notify Health Plan or Payor in writing within 10 days, and in any instance described in subsection (iv) above, Vendor must notify Health Plan or Payor in writing within 30 days, from the date it first obtains knowledge of the pending of the same.

14. Compliance with Regulatory Requirements. Vendor, 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 Vendor'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 Vendor or Contracted Providers from any Company or require Vendor or the Contracted Provider to reimburse Company for such amounts.

15. Program Integrity Required Disclosures. Vendor 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 Vendor 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 Vendor 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 Vendor; and (iii) 42 C.F.R. §455.106, relating to individuals with an ownership or controlling interest in Vendor, or who are managing employees of Vendor, who have been convicted of a crime.

16. Non-Exclusivity. Health Plan retains the right at all times to negotiate terms and enter into contracts with any other person or entity for services that are the same or similar to the Services without notice to Vendor and without incurring any liability by virtue thereof.

17. Compensation

17.1. Fees. In full consideration for Vendor's performance of the Services described in this Agreement, Health Plan shall pay the fees and, if applicable, expenses expressly described in Exhibit C, Compensation Schedule, ("**Fees**") subject to the terms of this Agreement and, for Covered Services, this Agreement and the Provider Manual. Vendor is not entitled to any compensation or remuneration other than the Fees. Excluding retroactive changes in the number of Clackamas County Health Plan members, under no circumstances shall Health Plan be liable for any Fees presented to Health Plan more than ninety (90) days after the date the underlying Services and/or Deliverables or expenses were provided or incurred, as the case may be. Health Plan may deduct from an invoice any credits or other amounts Vendor owes Health Plan hereunder.

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17.2. Encounter Data Submission. As provided in the Provider Manual and/or Policies, Contracted Providers shall submit to Payor or its delegate encounters 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 encounter data in accordance with the Provider Manual and/or Policies.

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

17.4. Hold Harmless. Vendor 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 Vendor or a Contracted Provider and a Covered Person.

17.5. Taxes. Vendor agrees to pay and hold Health Plan harmless against any penalty, interest, additional tax or other charges that may be levied or assessed as a result of the delay or failure of Vendor for any reason to pay any tax or comply with applicable federal and State tax laws.

17.6. Recovery Rights. Health Plan shall have the right to offset or recoup any and all amounts owed by Vendor or a Contracted Provider to Health Plan, Payor or Company against amounts owed by Health Plan, Payor, or Company to Vendor. Health Plan will provide to Vendor notice that includes the

reasons Vendor owes Health Plan and evidence supporting amounts owed. Vendor will have fourteen (14) days to dispute or agree with the evidence provided. Should Vendor require additional information, Health Plan will have seven (7) days to provide the information or provide reasoning for not providing the information. Should Health Plan state it is unable to provide the information both Parties shall negotiate alternative means of addressing Vendor's data needs. Vendor's 14-days-to-dispute clock will be considered "on hold" at such time as additional information is formally requested and until the provision of requested and/or negotiated data. Vendor 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 Vendor. In the event of a dispute, the Parties shall negotiate in good faith to resolve such dispute as soon as practicable.

17.7. Records and Audit. Except as expressly provided otherwise in this Agreement, until the expiration of ten (10) years after the furnishing of Services hereunder, Vendor shall maintain complete and accurate records to validate and document Vendor's (i) compliance with this Agreement, (ii) performance of the Services, and (iii) Fees and expenses, all in accordance with generally accepted accounting principles consistently applied.

17.7.1 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.

17.7.2 Vendor 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. Vendor 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. Vendor 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. Vendor and each Contracted Provider shall compile information necessary for the expeditious completion of such on-site inspection in a timely manner. Vendor shall also provide reasonable assistance to Health Plan or its designated agent in the conduct of audits. Any such audit will be conducted upon reasonable notice during regular business hours, and shall be at Health Plan's expense. All overcharges revealed by any audit hereunder shall be reimbursed to Health Plan within thirty (30) days of Health Plan's notice to Vendor regarding the same. In the event of a dispute regarding any audit results, the Parties shall negotiate in good faith to resolve such dispute as soon as practicable.

17.7. 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.

18. Delays in Services

18.1 Delays. Vendor will inform Health Plan as early as possible of any anticipated delays in the Services and of the actions being taken to ensure completion of the Services within a time period acceptable to Health Plan. In the event that the proposed plan of action is inadequate to meet Health Plan's contractual obligations to OHA, Vendor and Health Plan shall meet within 7 days of determination of inadequate plan in order to negotiate in good faith a plan to address contractual obligations. Vendor will notify Health Plan if demand for Services exceeds capacity and funding, and the parties will work together to either increase funding or decrease the number of clients served by Vendor. A Vendor's failure to utilize funding received for staffing to support Deliverables shall solely be the responsibility of the Vendor to address. Health Plan's acceptance of additional personnel as provided herein shall not be construed or implied to constitute a waiver of any of Health Plan's rights under this Agreement or Law, including but not limited to rights and remedies in connection with the breach of this Agreement.

18.2 Force Majeure. Neither Party will be liable for any default or delay in the performance of its obligations under this Agreement caused by events outside the party's reasonable control (including but not limited to, fire, flood, terrorism, pestilence, disease outbreak, earthquake, elements of nature or acts of God, riots, or civil disorders) beyond the reasonable control of such Party, provided (i) the non-performing Party is without fault in causing such default or delay, (ii) such default or delay could not have been prevented by reasonable precautions (including the implementation of, and adherence to, a prudent disaster recovery and business continuity plan), and (iii) such default or delay could not reasonably be circumvented by the non-performing Party through the use of alternate sources, workaround plans or other means.

18.8.1 Upon occurrence of a force majeure event, as soon as reasonably possible, Vendor will provide written notification to Health Plan informing the Health Plan of any services or deliverables adversely impacted by the event including, but not limited to, adverse impacts preventing Vendor from meeting any performance standards or delivering any reporting set forth in this Agreement or required by any applicable federal, state and local regulations. When safe to do so, both parties will collaborate to develop a plan to maximize service provision during the event and, to the extent commercially practicable, for re-implementing those service elements that they could not deliver or fully deliver, during the force majeure event.

19. Project Management

19.1. Vendor Project Personnel. Vendor shall staff each service included in the Scope of Services with sufficient qualified personnel to complete its obligations hereunder within available funding. Should Vendor's staff be unable to adequately perform necessary tasks so as to adversely impact Deliverables, Health Plan reserves the right to request the associated issue(s) be addressed. Should Vendor decide to move key staff currently involved in Health Plan Deliverables, Vendor will provide thirty (30) days' notice and provide a plan for ensuring Deliverables are met.

19.2. Reports. Vendor shall provide such written reports to Health Plan as set forth in this Agreement and as reasonably requested by Health Plan, no less than on a semi-annual basis. Additionally, should Vendor fail to meet one or more contract deliverables, Health Plan may request that Vendor shall present to Health Plan a written status report on deficit areas detailing Vendor's plan and progress in resolving the issues and completing Deliverables, on a task-by-task basis. These reports shall include any unanticipated issues and recommendations for dealing with such issues.

20. Warranties; Compliance with Law

20.1. Service and Performance Warranty. Vendor represents and warrants that it shall perform the Services in a timely, competent, workmanlike manner and in conformance with the requirements of this Agreement, and that all Deliverables will conform to their documentation, functional specifications and requirements.

20.2. Mutual Warranties. Each Party represents and warrants to the other that: (i) it is validly existing under the laws of the state of its formation and has the full right, authority, capacity and ability to enter into this Agreement and to carry out its obligations hereunder; (ii) this Agreement is a legal and valid obligation binding upon the Parties and enforceable according to its terms; and (iii) the execution, delivery and performance of this Agreement does not conflict with any agreement, instrument or understanding, oral or written, to which the Party is bound.

20.3. Compliance with Law. Vendor and each Contracted Providers shall provide the Services in compliance with the requirements of all applicable federal, state and local statutes, ordinances, executive orders, regulations and codes and any applicable regulatory guidance, judicial or administrative rulings, requirements of applicable governmental contracts and, if applicable, standards and requirements of any accrediting or certifying organization (collectively, "**Law**" or "**Laws**"). Vendor agrees to report any violation of Law committed by Vendor, its employees or subcontractors in the performance of the Services to Health Plan's Compliance Hotline at (866) 685-8664 or Health Plan's Compliance Officer at Health Plan's address for Notices. To the extent permitted by Article XI, Section 7 of the Oregon Constitution and by the Oregon Tort Claims Act, County shall be responsible for any sanctions or penalties that are imposed on County to the extent the reason for the imposition of sanctions or penalties is reasonably attributable to the action or inaction of County in performing its obligations under this Agreement, and provided further that under no circumstances will County be required to pay for any sanctions or penalties assessed against Health Plan that are not caused by the actions or inactions of County. For purposes of the Health Plan's current CCO contract and this Agreement, all references to Laws are references to 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, Vendor shall comply with the following federal requirements to the extent that they are applicable to the CCO Contract and this Agreement.

Without limiting the generality of the foregoing, Vendor and each Contracted Provider expressly agrees to comply with the following laws, regulations and executive orders to the extent they are applicable to the CCO Contract and this Agreement: (a) Titles 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 laws requiring reporting of Covered Person abuse. These laws, regulations and executive orders are incorporated by reference herein to the extent that they are applicable to the CCO Contract and this Agreement and required by law to be so incorporated. No federal funds may be used to provide services under this Agreement in violation of 42 USC 14402.

20.4. Required CCO Contract Language**.** The applicable provisions set forth in the CCO Contract and the attached Exhibit D OHP Product Attachment are specifically incorporated by this reference into this Agreement in the event that this Agreement applies to OHP beneficiaries. In the event there is a conflict between the language in this Agreement and the applicable contract provisions in Exhibit D, then Exhibit D shall control.

20.5. Vendor, Affiliates and Subcontractors Providing Services to Health Plan. Vendor represents that Vendor and its affiliates (including, without limitation, any person controlling or under common control with Vendor or in which Vendor has a five percent (5%) or more ownership interest), and their respective employees, officers, directors, representatives, and subcontractors providing Services to Health Plan under this Agreement have not been debarred, suspended or otherwise excluded from participating in: (i) procurement activities under the Federal Acquisition Regulation, or (ii) non-procurement activities under regulations or guidelines implementing or issued under Executive Order No. 12549. Vendor also represents that neither Vendor nor its affiliates, nor any of their respective employees, officers, directors, representatives and subcontractors providing Services to Health Plan under this Agreement: (i) has been or is excluded from Medicare, Medicaid or another federal health care program participation under Sections 1128 or 1128A of the Social Security Act for, among other things, the provision of health care, utilization review, medical social work, or administrative services, or who could be excluded under Section 1128(b)(8) of the Social Security Act as being controlled by a sanctioned individual; (ii) has been or is excluded, disqualified, debarred, suspended or proposed for debarment by the General Services Administration, the Department of Health and Human Services Office of the Inspector General, or other or successor federal or state agency from participation in federal or state health care programs or government procurement or nonprocurement activities or programs; (iii) has been or is discharged or suspended from doing business with any state; or (iv) has been convicted of certain crimes described in Section 1128(b)(8) of the Social Security Act or has a contractual relationship (direct or indirect) with an individual or entity that has been convicted of such crimes. Vendor shall notify Health Plan in writing immediately upon it having knowledge of any investigation, proposal, or action that may result in such an exclusion, disqualification, debarment or suspension of it or any of its affiliates or their respective employees, officers, directors, representatives, including any contractors or subcontractors providing Services to Health Plan under this Agreement, and shall immediately cease using any such person in connection with this Agreement. Upon receipt of such notice or within a reasonable time thereafter, Health Plan may terminate this Agreement by giving written notice thereof to

Vendor if Health Plan determines that such termination is necessary or appropriate in order to comply with applicable federal or state law.

21. Confidential Information.

21.1. Except as otherwise required by applicable Laws, County agrees not to disclose and shall prohibit its Contracted Providers from disclosing to any third party any Confidential Information, as defined in this Section 21, that is disclosed to County or its Contracted Providers as a result of County's participation in this Agreement. **"Confidential Information"** will mean all information provided by one Party (or Affiliate or Contracted Provider thereof) to this Agreement to another in connection with this Agreement, which is designated "confidential" and/or considered a trade secret under applicable Laws. Each Party agrees that it will not make use of, disseminate, disclose or in any way circulate any Confidential Information supplied to or obtained by such Party in writing, orally or by observation, except as expressly permitted by this Agreement or as required by applicable Laws or order of a court or administrative agency having jurisdiction. Confidential Information may be used as necessary to perform the services required under this Agreement and may be disclosed by a Party to this Agreement to its own employees that require access to such Confidential Information for the purposes of this Agreement. This paragraph does not prevent disclosure in connection with an audit or survey in the normal course of business by regulatory authorities, certified public accountants, accrediting institutions and the like; provided the recipient is under a duty to protect the confidentiality of the information disclosed.

21.2. County agrees that if it receives a public record request seeking any Confidential Information, County shall provide prompt written notice to Health Plan describing the Confidential Information that is the subject of such request and the circumstances of the request, so that Health Plan has the option to seek an appropriate protective order.

22. Term and Termination

22.1. Term. The term of this Agreement commences on the Effective Date and ends on December 31, 2025.

22.2. Termination without Cause. Either Party may terminate this Agreement with 180 days' written notice to the other Party. This Agreement is not transferable without the written consent of both Parties. 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, Vendor shall immediately notify the affected Contracted Provider of such termination.

22.3. Termination if CCO Contract Terminates. In the event the CCO Contract is terminated for any reason, this Agreement terminates on the effective date of termination of the CCO contract. Vendor shall provide services after termination of this Agreement as specified in Section 22.17.

22.4. Termination for 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 22.10 must describe the specific breach. In the case of a termination of a Contracted Provider, Vendor shall immediately notify the affected Contracted Provider of such termination. Health Plan shall notify Vendor and OHA in writing within thirty (30) calendar days of Health Plan terminating this Agreement when such termination is due to Vendor's failure to meet requirements under the CCO Contract, to deficiencies identified through compliance monitoring of the Vendor, or to any other for-cause reason for termination.

22.5. 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 Vendor 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. Vendor 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.

22.6. 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.

22.7. 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 Vendor 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. Vendor shall immediately notify the affected Contracted Provider of such termination.

22.8. Breach of CCO Contract. Vendor will be in material breach of this Agreement if Vendor's failure to perform any of its duties hereunder directly causes Trillium to be in breach of the CCO Contract.

22.9. Remedies. Notwithstanding anything in this Agreement to the contrary, where a breach of certain provisions of this Agreement may cause either Party irreparable injury or may be inadequately compensable in monetary damages, either Party may seek such equitable relief in addition to any other remedies which may be available. The rights and remedies of the Parties in this Agreement are not exclusive and are in addition to any other rights and remedies available at law or in equity.

22.10. Termination for Nonpayment. If Trillium fails to pay Vendor any amount owed to Vendor under this Agreement when due, Vendor may give notice to Trillium of intent to terminate for nonpayment. If payment in full of the amount due is not made within sixty (60) business days of the date of the notice, Vendor can terminate this Agreement immediately, provided, however, that Vendor fulfills the obligations set forth in Section 22.17 of this Agreement.

22.11. Effect of Termination..

22.17.1 Upon the termination or expiration of this Agreement, Vendor shall: (a) deliver to Health Plan all Deliverables, whether or not in completed form, in whatever form or media they may then exist; (b) document the status of the Services that have been terminated and deliver such documentation to Health Plan; and (c) deliver to Health Plan all fees paid by Health Plan for Services and Deliverables that remain unperformed or undelivered as of the date of termination as well as all Health Plan property and materials that are in the possession of Vendor, its employees, subcontractors and agents. The termination or expiration of this Agreement for any reason shall not affect Health Plan's or Vendor's rights or obligations for any Services or Deliverables completed and delivered to Health Plan prior to the date of termination, and Health Plan shall promptly pay all undisputed amounts owed to Vendor for such Services and Deliverables.

22.17.2 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 Vendor, 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 Vendor, 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 17.4 (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.

23. Indemnification by Vendor and Contracted Provider. **Subject to the limits of the Oregon Constitution and the Oregon Tort Claims Act or successor statutes.** Vendor 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 Vendor, a Contracted Provider, or any of their respective officers, directors, agents or employees.

24. Indemnification by Health Plan. Health Plan agrees to indemnify and hold harmless (and at Vendor's request defend) Vendor, 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.

25. Informal Dispute Resolution. Any dispute between Vendor 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 26 below by providing written notice to the other party.

26. Arbitration. If either the Provider Party or the Administrator Party wishes to pursue the Dispute as provided in Section 25, such party shall submit it to binding arbitration conducted in accordance with the Commercial Arbitration Rules of the American Arbitration Association ("AAA"). In no event may any arbitration be initiated more than 1 year following, as applicable, the end of the 60 day negotiation period set forth in Section 25, or the date of notice of termination. Arbitration proceedings shall be conducted by an arbitrator chosen from the National Healthcare Panel at a mutually agreed upon location within the State. The arbitrator shall not award any punitive or exemplary damages of any kind, shall not vary or ignore the provisions of this Agreement, and shall be bound by controlling law. Any arbitration in which the total amount in controversy is less than $100,000 shall be conducted in a single hearing day. The Parties and the Contracted Providers, on behalf of themselves and those that they may now or hereafter represent, agree to and do hereby waive any right to pursue, on a class basis, any Dispute. Each of the Provider Party and the Administrator Party shall bear its own costs and attorneys' fees related to the arbitration except that the AAA's Administrative Fees, all Arbitrator Compensation and travel and other expenses, and all costs of any proof produced at the direct request of the arbitrator shall be borne equally by the applicable parties, and the arbitrator shall not have the authority to order otherwise. The existence of a Dispute or arbitration proceeding shall not in and of itself constitute cause for termination of this Agreement. Except as hereafter provided, during an arbitration proceeding, each of the Provider Party and the Administrator Party shall continue to perform its obligations under this Agreement pending the decision of the arbitrator. Nothing herein shall bar either the Provider Party or the Administrator Party from seeking emergency injunctive relief to preclude any actual or perceived breach of this Agreement, although such party shall be obligated to file and pursue arbitration at the earliest reasonable opportunity. Judgment on the award rendered may be entered in any court having jurisdiction thereof. Because of the confidential nature of this Agreement, the Provider and

Administrator Parties further agree that in any action to compel arbitration or enforce any arbitration award, no party may file any part of this Agreement (including Attachments) in the court record, except this Section 26. Nothing contained in this Article VI shall limit a Party's right to terminate this Agreement with or without cause in accordance with Section 22.

27. Insurance.

27.1. Insurance Maintained by County. During the term of this Agreement and for any applicable continuation period as set forth in Section 22.17 of this Agreement, Vendor and/or each Contracted Provider shall maintain policies of general and professional liability insurance and other insurance necessary to insure Vendor and such Contracted Provider, respectively; their respective employees; and any other person providing services hereunder on behalf of Vendor 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 include, but not be limited to, any "tail" or prior acts coverage necessary to avoid any gap in coverage. Insurance shall be through a licensed carrier acceptable to Health Plan, and 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. Vendor 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, Vendor and each Contracted Provider will furnish Health Plan with evidence of such insurance. Vendor will fulfill its insurance obligation through a program of self-insurance, provided that Vendor's self-insurance program complies with all applicable laws, and provides insurance coverage equivalent in both type and level of coverage to that required by the State.

27.2. Insurance Maintained by Trillium. Trillium will obtain and maintain Risk/Private Market Reinsurance pursuant to the requirements within the CCO Contract. Trillium will obtain and maintain all other insurance pursuant to the requirements within the CCO Contract.

28. Miscellaneous.

28.1. Use of Name; Publicity. Vendor 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. Vendor 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. Except for the uses described in this section, its internal business use, as required by Law or to comply with the request of a governmental entity, neither Party shall use the other Party's name, trademarks, service marks, logos or other identifiers (collectively, "**Trademarks**"), or make any reference to the other Party or its Trademarks in any manner including, without limitation, client lists and press releases without the prior written approval of such other Party, to be obtained through the party of notice as listed in paragraph 28.2 below.

28.2. Notices. Unless otherwise provided herein, any notice, consent, request, or other communication to be given under this Agreement will be deemed to have been given by either Party to

the other Party upon the date of receipt, if hand delivered; or three (3) business days after deposit in the U.S. mail if mailed to the other Party by registered or certified mail, properly addressed, postage prepaid, return receipt requested; or one (1) business day after deposit with a national overnight courier for next business day delivery; or upon the date of electronic confirmation of receipt of a facsimile transmission if followed by the original copy mailed to the applicable Party at its address above or other address provided in accordance herewith; or upon the date of transmission of electronic notice to an authorized email address with written confirmation of receipt. Either Party may change its address for notices effective three (3) business days after providing written notice to the other Party. All notices to the other Party are to be addressed to the persons below.

For: Clackamas County
Mary Rumbaugh
Behavioral Health Director
Clackamas County Behavioral Health Division
2051 Kaen Road
Oregon City, OR 97045
MaryRum@clackamas.us
503-742-5335

For: Trillium

Attn: VP/Director, Compliance
Trillium Community Health Plan
555 International Way, Building B
Springfield, OR 97477
541-485-2155

28.3. Assignment. This Agreement and the duties and obligations of Vendor hereunder are of a unique and personal nature and may not be delegated or assigned (in whole or in part) by Vendor without Health Plan's prior written consent. Any assignment or delegation made by Vendor without Health Plan's written consent is void. The provisions of this Agreement are binding upon and inure to the benefit of the Parties hereto and their respective permitted successors and assigns.

28.4. Amendments and Modifications. Except as expressly provided otherwise herein, no addition to or change in the terms of this Agreement will be effective or binding on either of the Parties unless reduced to writing and signed by a duly authorized representative of each Party.

28.5. CCO Contract Amendments: This Agreement may be amended upon the mutual written agreement of the Parties to comply with any agreement entered into between Trillium and OHA or to comply with any change in applicable law or regulation which affects the validity of any portion of this Agreement. Such amendment shall be documented by written amendment to this agreement after a 30-day notice and no written objection. If such amendment has a material adverse effect on Vendor, Vendor may object to the amendment in writing within 30 days of notice of the amendment. If Vendor objects, such amendment will not go into effect during the time that Health Plan and Vendor negotiate contract terms that address objections in order to meet OHA requirements.

28.6. Relationship of Parties. The relationship between or among Health Plan, Company, Vendor, 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.

28.7. 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.

28.8. Approval of Subcontractors. Vendor shall obtain Health Plan's written consent before entering into agreements with any new subcontractors for the performance of the Services or portion thereof. Such Health Plan consent shall not be unreasonably withheld. Should Health Plan identify a performance concern with a subcontractor, Health Plan will notify Vendor and work with Vendor to develop a mutually agreeable response to the concern. In the event that concerns are related to health and safety of Members, Vendor shall take such steps necessary to ensure Member safety while addressing performance concerns. Vendor shall ensure that any and all subcontractors are insured in accordance with the insurance provisions of this Agreement, and Vendor shall be responsible for all acts or omissions of its subcontractors.

28.9. Nondiscrimination. This Agreement is subject to the affirmative action and nondiscrimination requirements of Executive Order 11246 as amended, Section 503 of the Rehabilitation Act of 1973, and Section 402 of the Vietnam Era Veterans' Readjustment Assistance Act of 1974, and with all rules, regulations, pertaining thereto, which are incorporated herein by specific reference. Vendor agrees not to discriminate in its provision of Services to Health Plan Members on the basis of: race, color, national origin, ethnicity, ancestry, religion, sex, marital status, sexual orientation, mental or physical disability, medical condition or history, age, genetic information, source of payment, claims experience, receipt of health care, mental or physical condition, disability or illness, evidence of insurability, including conditions arising out of acts of domestic violence (42 CFR 422.110) or any other characteristic or classification deemed protected under state or federal law. Vendors agrees to provide Services to Health Plan Members in the same manner, in accordance with the same standards, and within the same time availability as offered to non-Plan clients of Vendor consistent with existing medical ethical/legal requirements for providing continuity of care to any client.

28.10. Headings; Captions. Section headings are used for convenience only and shall in no way affect the construction or interpretation of this Agreement.

28.11. Counterparts; Time is of the Essence. This Agreement and any subsequent amendments may be executed in counterparts and by facsimile or emailed PDF signature, all of which taken together constitute a single agreement between the Parties. Each signed counterpart, including a signed counterpart reproduced by reliable means (such as facsimile and emailed PDF), will be considered as legally effective as an original signature. The Parties acknowledge and agree that time is of the essence in this Agreement.

28.12. Survival. 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 10, 12, 17, 17.4, 17.6, 17.7, 18.2, 21, 22.17, 23, 24, 26, 27, 28.18, and 28, survive the expiration or termination of this Agreement.

28.13. Waiver and Severability. An individual waiver of a breach of any provision of this Agreement requires the written consent of the Party whose rights are being waived, and such waiver will not constitute a subsequent waiver of any other breach. If a court of competent jurisdiction declares any provision of this Agreement invalid or unenforceable, such judgment shall not invalidate or render unenforceable the remainder of the Agreement, provided the basic purposes of this Agreement are achieved through the provisions remaining herein.

28.14. Governing Law. This Agreement will be governed by and construed in accordance with the laws of the State of Oregon, without regard to any conflict of law principles. Any suit or proceeding relating to this Agreement shall be brought only in the state or federal courts located in Oregon, and each Party hereby submits to the personal jurisdiction and venue of such courts.

28.15. 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 Vendor, the benefit of each Contracted Provider. Except as specifically provided in Section 17.4 hereof, no Covered Person or third party, other than Company, will be considered a third party beneficiary of this Agreement.

28.16. Equal Opportunity. Vendor and its subcontractors shall abide by the requirements of 41 CFR 60-300.5(a) and 60-741.5(a). These regulations prohibit discrimination against qualified individuals on the basis of protected veteran status or disability, and require affirmative action by covered prime contractors and subcontractors to employ and advance in employment qualified protected veterans and individuals with disabilities.

28.17. Conflicts of Interest. Vendor shall ensure that its personnel do not have conflicts of interest with respect to Health Plan and the Services. "Conflict of Interest" includes activities or relationships with other persons or entities that may result in a person or entity being unable or potentially unable to render impartial assistance or advice to Health Plan, or the person's objectivity in performing the contract work is or may be impaired, or a person has an unfair competitive advantage.

28.18. Litigation Assistance. Vendor shall make itself and any subcontractors, employees or agents assisting in the performance of its obligations under this Agreement, available at no cost to Health Plan to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against Health Plan, its directors, officers or employees based upon claimed violation of contract or laws, to the extent such testimony is necessary. Health Plan shall pay reasonable market rates to Vendor to the extent that Health Plan retains Vendor to provide expert witness testimony.

28.19. Entire Agreement. This Agreement and all its exhibits and addenda thereto are incorporated herein and constitute the entire agreement of the Parties. This Agreement supersedes all prior and contemporaneous negotiations, representations, promises, and agreements concerning the subject matter herein whether written or oral.

28.20. Authority. The individuals whose signatures are set forth below represent and warrant that they are duly empowered to execute this Agreement. Vendor 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.

28.21. Rights and Obligations of Health Plan, Payor. Vendor 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.

IN WITNESS WHEREOF, the Parties have caused this Agreement to be executed by their duly authorized representatives as of the Effective Date.

For: Clackamas County	For: Trillium Community Health Plan
Signature	Signature
Name	Name
Title	Title
Date	Date

LIST OF SCHEDULES AND EXHIBITS

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 27.7 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 27.7 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 Schedule, "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.

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:
Exhibit D: Oregon Health Plan Product Attachment

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.

EXHIBIT A

SCOPE OF SERVICES

1. Delegated Services (as set forth in Exhibit B, Delegated Services Agreement, attached to this Agreement):
    a. Behavioral Health Crisis Services
    b. Wraparound Care Coordination Services
    c. Choice Care Coordination Services

2. Health Care Services. The following Health Care Services shall be provided by County and/or its Contracted Providers, as set forth in Exhibit B:
    a. Mobile Crisis and Mobile Crisis Intervention Services

3. Other County Behavioral Health Services Administration: Supervision and management of care coordination services and oversight and management of provider contracts related to the Behavioral Health Crisis Services including contract coordinator, quality and compliance oversight and fiscal.

4. Peer and Community-Based Services (not subject to Exhibit B, Delegated Services Agreement): County administration and coordination of funding for targeted local and regional efforts that supplement covered clinical treatment to assist individuals in remaining in the least restrictive setting possible. Peer and Community-Based Services providers are not Contracted Providers as that term is defined and used in this Agreement. Peer Services provide support from individuals with lived experience to community members with similar conditions. County provides peer services to unconnected members through drop in centers and peers placed at various access points throughout the county such as the jail, community corrections and crisis services. Peer program supported with this funding include:

    (i) Peer Drop In Centers-both youth and adults
    (ii) 1:1 Mental health and Recovery Peer Support
    (iii) Peer support at Urgent Mental Health Crisis Clinic

    Clackamas County Behavioral Health Division Peer Services Coordinator provides coordination of peer services across the county.

EXHIBIT B

DELEGATED SERVICES AGREEMENT

This Delegated Services Agreement (together with all attachments, exhibits, schedules and addenda hereto, this "**Delegated Services Agreement**" or "**Attachment**"), entered as of the Effective Date of the Agreement, by and between Trillium Community Health Plan, Inc. ("**Health Plan**") and Clackamas County (such delegate to be referred to herein as "**County**" or "**Vendor**") on behalf of itself and its contracted providers ("**Vendor Providers**"), sets forth the terms and conditions under which Health Plan shall delegate to Vendor specific managed care activities.

WHEREAS, the Parties have entered into an Administrative Services Agreement entered as of the Effective Date (the "**Vendor Agreement**" or the "**Agreement**"), to which this Attachment is attached and incorporated, whereby Vendor agrees to arrange for the provision of Covered Services to Covered Persons in exchange for certain compensation, and in connection with which the Parties desire for Vendor to provide certain delegated administrative services pursuant to this Attachment; and

WHEREAS, Health Plan has completed its review of, if and as applicable, Vendor's quality management program, operational standards, invoice and claim processing and payment system, utilization review processes, and management information system and has determined that it can appropriately delegate to Vendor specific managed care activities as identified in this Attachment; and

WHEREAS, the Parties have determined that delegation of specific managed care activities would be beneficial to both Parties.

NOW THEREFORE, the Parties agree as follows:

1. Definitions. The following terms as used in this Attachment shall have the definitions as set forth below. Capitalized terms not defined herein shall be defined as set forth in the Vendor Agreement.

"***Agency***" means the DOI, State Medicaid Agency, Centers for Medicare and Medicaid Services, or other applicable federal or State governmental agency.

"***Covered Services***," unless otherwise defined in the Vendor Agreement, means covered health care or other services, products or supplies that are rendered, or are sold or arranged for, by or on behalf of Health Plan, and that constitute covered benefits under the terms of a covered benefit plan entered into or sponsored by Health Plan or a related or third party health insurance company or health benefit program that contracts with Health Plan.

"***Covered Persons***" (or "***Members***"), unless otherwise defined in the Vendor Agreement, means individuals entitled to receive Covered Services.

"***DOI***" means the State Department of Insurance.

"***State***," unless otherwise defined in the Vendor Agreement, shall mean the state in which the applicable Covered Persons reside.

"***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, and where applicable, includes but is not limited to the requirements set forth in any Product Attachment attached to the Vendor Agreement.

2. Delegated Services. Pursuant to the Vendor Agreement and this Attachment, Health Plan hereby delegates to Vendor the activities set forth in Exhibit B-1 to this Attachment. All Vendor's programs, work plans, and policies and procedures shall comply with all Regulatory Requirements. The following services may be delegated hereunder, as applicable (such services to be referred to as "**Delegated Services**"). For the purposes of this Attachment, all attachments, exhibits, schedules and addenda that are referenced herein and attached hereto are hereby incorporated in this Attachment. Services below are "applicable" to Vendor to the extent indicated in Exhibit B-1 to this Attachment.

a.) Behavioral Health Crisis Services. Vendor shall perform all Crisis Services functions as detailed in Exhibit B-3.

b.) Wraparound Care Coordination Services. Vendor shall perform all Wraparound care coordination functions as detailed in Exhibit B-4.

c.) Choice Care Coordination Services. Vendor shall provide all Choice care coordination functions as detailed in Exhibit B-5.

3. Oversight of Delegated and Contracted Services. Vendor hereby agrees to accept all responsibilities associated with the delegation provided under this Attachment, and specifically agrees to abide by the current policies and procedures, as of the Effective Date, set forth or referenced in this Attachment or in the Health Plan's Oversight of Delegated Services Policy and Monitoring Plan (the "**Policy**"), which is attached hereto as Exhibit B-2. Should the policies and procedures need to be amended or supplemented by Health Plan, in a manner that impacts Vendor's cost, Health Plan and Vendor will negotiate associated deliverables in order to minimize adverse cost impact and/or fees paid. Vendor's material deviations from the Policy and/or procedures set forth herein may result in review and action by Health Plan, including rescission or termination of this Attachment or any Delegated Services hereunder and/or the assessment of penalties as described herein. Nothing in this Attachment shall be construed in any way to limit Health Plan's authority or responsibility to comply with all Regulatory Requirements. Vendor shall, and Vendor acknowledges that Health Plan may take whatever action is deemed necessary by Health Plan and/or any applicable Agencies to assure that Vendor shall, comply with all Regulatory Requirements relating to any function, duty, responsibility or delegation assumed by or carried out by Vendor.

3.1 Reports. Vendor shall produce such reports as may reasonably be requested by Health Plan and outlined in the Agreement. Reports will be sent to Health Plan on or before the due dates and at the frequency set forth in the applicable Exhibits, at a minimum of semi-annually. The report requirements shall be subject to modification at Health Plan's discretion based on, among other things, new contract requirements or identified performance issues with Vendor. Additional report requirements that are ongoing in nature will be discussed with the Vendor prior to implementation. Additionally, Vendor must

provide Health Plan with any reports that are intended to be sent to an Agency within the timeframes specified by Health Plan, which may include such time as may be necessary to review such reports for quality and accuracy.

3.2 File Reviews. Vendor shall give Health Plan access, upon request, to Vendor's files for Health Plan's review. Such files may exclude bona fide confidential peer review files. At least annually, or more frequently if deemed necessary by Health Plan representatives, Vendor or Vendor Provider, as applicable, will permit Health Plan to perform on-site performance compliance review, including without limitation review of any verification and re-verification files, upon not less than ten (10) days written notification by Health Plan. Upon request, Vendor shall provide copies of requested files (i) promptly following Health Plan's request if the request is made during such on-site review, and (ii) upon not less than ten (10) days following Health Plan's request if the request is made outside of any such on-site review.

3.3 Policy Notifications. Health Plan retains the right to modify relevant policies and procedures of Vendor, as necessary, to assure compliance with Regulatory Requirements. Vendor shall have thirty (30) calendar days following written notification from Health Plan to propose alternatives to Health Plan's modifications of Vendor's policies and procedures. In the event Vendor accepts Health Plan's modifications, or upon resolution of any issues related to the proposed modifications, Vendor shall have no more than sixty (60) calendar days to demonstrate compliance with modification requirements unless a lesser timeframe is required under Regulatory Requirements.

3.4 Corrective Action Plans. Vendor agrees to comply with (a) Health Plan's specific recommendations regarding deficiencies in Vendor's Delegated Services identified by Health Plan; (b) reasonable time frames for resolution of any such deficiencies; and (c) any re-reviews of Vendor's programs by Health Plan. In the event that Vendor's performance of delegated activities is considered unsatisfactory by Health Plan, Health Plan shall initiate the Corrective Action process as described in the attached Exhibit B-2 to this Attachment.

3.5 Health Plan's Decisions. Notwithstanding anything to the contrary in this Delegated Services Agreement or the Vendor Agreement generally, Health Plan retains the right, based on its sole judgment, to approve, suspend, or terminate any Vendor Provider from participation in Health Plan's provider network system. Health Plan agrees to notify Vendor of its decision and Vendor shall have fourteen (14) calendar days from such notice to request reconsideration of such decision by Health Plan. Health Plan shall have the final decision on any such verification matter.

4. Sub-delegation. Any engagement by Vendor of a third party subcontractor (a "**Sub-Delegate**") to perform any Delegated Services hereunder shall be deemed a sub-delegation of such Delegated Services. Vendor shall obtain Health Plan's written consent before entering into agreements with any new subcontractors for the performance of the Services or portion thereof. Such Health Plan consent shall not be unreasonably withheld. Should Health Plan identify a performance concern with a subcontractor, Health Plan will notify Vendor and work with Vendor to develop a mutually agreeable response to the concern. In the event that concerns are related to health and safety of members, Vendor shall take such steps necessary to ensure member safety while addressing performance concerns. Vendor shall ensure that any and all subcontractors are insured in accordance with the insurance provisions of this Agreement and Vendor shall be responsible for all acts or omissions of its subcontractors in the

performance of Services under this contract, unless due to intentional acts or criminal behavior in violation of the subcontractor's delegated responsibilities under the Agreement.

Vendor shall be responsible for conducting oversight of Sub-delegate's performance and for ensuring Sub-delegate's compliance with the terms of this Attachment and agrees to participate in Health Plan's required monitoring and delegation oversight activities in accordance with the applicable standards listed in Exhibit B, Part 4, Section 12.a of the CCO Contract. Vendor shall provide evidence of such Sub-delegate oversight to Health Plan upon request and shall support and assist Health Plan in the development and reporting of its Annual Subcontractor Performance Report, as described in Exhibit B, Part 4, Sections 12.a.13 through 12.a. 15 of the CCO Contract.

The role of Vendor and any Subdelegate in relation to Health Plan is limited to performing those Delegated Services set forth herein, in compliance with Regulatory Requirements, and subject to Health Plan's oversight and monitoring of Vendor's performance.

Health Plan retains the right to modify, rescind or terminate, at any time, any one or all of the Delegated Services under this Attachment, notwithstanding the sub-delegation of such Delegated Services as set forth in this Attachment. In addition, CMS and any other applicable Agency reserves the right to revoke any one or all of the Delegated Services and reporting requirements under this Attachment, or to specify other remedies in instances where CMS or other applicable Agency Health Plan or the Payor determine that Vendor or any Sub-delegate has not performed satisfactorily.

5. Material Changes. Vendor shall provide written notice to Health Plan at least thirty (30) days prior to making any material changes to Vendor's procedures and processes relevant to the Delegated Services under this Attachment.

6. Compensation. The compensation to be paid by Health Plan to Vendor for performance of Delegated Services described herein, if any, shall be included in the compensation paid by Health Plan pursuant to the terms of the Vendor Agreement. No additional compensation shall be paid under the terms of this Attachment.

7. Termination. Health Plan reserves the right, upon 60-day written notice to Vendor, to terminate this Delegated Services Agreement or rescind any of the Delegated Services or activities delegated to Vendor herein for cause or for business reasons as deemed necessary by Health Plan. Notwithstanding the foregoing, unless otherwise agreed to by the Parties, this Attachment shall automatically terminate upon termination of the Vendor Agreement. Termination of this Attachment shall not affect the rights and obligations of the Parties under the Vendor Agreement, except that delegation contemplated under the Vendor Agreement, as well as any payment for Delegated Services provided for under the Vendor Agreement, shall cease to be effective on the effective date of the termination or recession of such Delegated Services under this Attachment.

In the event this Attachment terminates, or the delegation of verification or re-verification services are rescinded hereunder, providers verified and re-verified by Vendor will be requested by Vendor to complete Health Plan's verification and re-verification process in order to maintain Health Plan participation, and Vendor shall provide any and all files and records as may be required to transfer

verification and re-verification to Health Plan. Vendor shall obtain any and all physician and/or provider releases that may be necessary to effectuate such transfer.

8. Performance Standards. Vendor's performance of the delegated activities described in this Attachment shall be subject to the performance standards set forth in the Vendor Agreement, and Health Plan shall have the right to assess the penalties set forth in the Vendor Agreement against Vendor for the failure to meet such performance standards.

9. Performance Noncompliance. Vendor shall be responsible for the cost of any penalty or administrative sanctions assessed against Vendor by any Agency on the basis of late payment of invoices or claims by Vendor for Covered Services or other services as defined in the Vendor Agreement. Health Plan reserves the right to initiate a corrective action process with Vendor for noncompliance with a material provision this Attachment. Health Plan shall provide Vendor with written notice of the noncompliance and, except in cases involving a threat of imminent harm to the safety and welfare of Covered Persons, shall provide Vendor with thirty (30) days to cure the area of noncompliance. Vendor shall notify Health Plan of any sanctions incurred or issued to Vendor following review by an Agency or voluntary accreditation agency.

10. Reporting Compliance. Vendor shall comply with the same encounter, utilization, quality, and financial reporting requirements as Health Plan must comply with under any applicable payor agreement, including but not limited to any contract that Health Plan may have with an Agency for the provision of managed care or other administrative services.

11. Vendor Materials. Vendor shall provide Health Plan with a copy of its member communication materials, including but not limited to education materials, for Health Plan to submit to the applicable Agency for approval prior to distribution of such materials to Covered Persons.

13. Confidentiality. Vendor shall comply with all Regulatory Requirements relating to patient confidentiality, including but not limited to HIPAA regulations. If the Delegated Services contemplated hereunder require that Vendor create, receive, transmit, maintain and/or disclose "protected health information" (as such term is defined under HIPAA) on behalf of Health Plan, Vendor shall not perform such Delegated Services until Vendor has executed a Business Associate Agreement with Health Plan.

14. Agreement Conflict. In the event of a conflict between this Attachment and the Vendor Agreement, the terms of this Attachment shall govern as to the delegation of responsibilities hereunder.

15. Member Experience/Clinical Performance. Health Plan agrees to provide member experience (i.e., member surveys, member inquiries/complaints/grievances, as applicable) and clinical performance data relating to Vendor's performance under this Attachment to Vendor within a reasonable time period following Vendor's request.

16. Standards. Health Plan is responsible for meeting and maintaining compliance with current NCQA Accreditation and/or URAC standards, as applicable. County will collaborate with Health Plan to support coordination of efforts to adhere to such standards, as applicable to the scope of work defined in this Agreement.

IN WITNESS WHEREOF, the Parties have caused this Delegated Services Agreement to be executed by their duly authorized representatives as of the Effective Date.

For: Clackamas County	For: Trillium Community Health Plan
Signature	Signature
Name	Name
Title	Title
Date	Date

EXHIBIT B-1
TO DELEGATED SERVICES AGREEMENT

The following services that are checked shall be delegated to Vendor:

☒	**Behavioral Health Crisis Services as outlined in Exhibit B-3**
☒	**Wraparound Care Coordination Services as outlined in Exhibit B-4**
☒	**Choice Care Coordination Services as outlined in Exhibit B-5**

EXHIBIT B-2
TO DELEGATED SERVICES AGREEMENT
OVERSIGHT OF DELEGATED SERVICES POLICY AND MONITORING PLAN

This Exhibit B-2 (this "**Policy**") describes the Health Plan's oversight program as it relates to vendors of delegated administrative services (the "**Vendor Oversight Program**"). All capitalized terms used in this Policy shall have the definitions ascribed to them in the Delegated Services Agreement, to which this Policy is attached and in which it is incorporated.

I. Introduction

Health Plan may delegate certain activities that relate to benefit management, invoices/claims payment and processing, encounters, care management, health risk assessments, disease management, practitioner/provider network and services, population health management, credentialing, customer service, quality assurance, or utilization management, solely or in combination. At all times, Health Plan shall maintain responsibility for arranging for the provision of health care services to its members. Health Plan has established, operates, and maintains a health care financing and payment system, quality assurance system, provider verification system and other systems and programs meeting applicable Regulatory Requirements, and is directly accountable for compliance with such standards. Health Plan may take whatever action it deems necessary to assure that all its systems and functions are in full compliance with all Regulatory Requirements. The Vendor Oversight Program as described in this Policy assists into assuring that delegated services meet Health Plan standards for care and service, as well as all Regulatory Requirements.

Health Plan's Board of Directors has responsibility for the Vendor Oversight Program. It delegates implementation of the Program to Health Plan's Quality Committee. The Quality Committee shall review initial oversight audits and approve delegated status; review delegation reports, quarterly evaluations and annual assessments; approve and monitor corrective actions; and recommend changes to the Vendor Oversight Policy. The Quality Management Vice President/ Director, or designee, shall be responsible for initiating and monitoring the Vendor Oversight Program.

The contractual language between Health Plan and the Vendor shall specify the delegated activities, the Vendor's accountability for these activities; the frequency of reporting to Health Plan; and the process by which the delegation shall be evaluated.

The Health Plan's Vendor Oversight Program shall be evaluated yearly as part of the annual Quality Management Program appraisal. In addition, interim modifications, consistent with changes in regulatory requirements or other business requirements, may be required. At all times, the most current revision of this Policy shall direct the oversight activity for each Vendor.

II. Initial Evaluation

Prior to executing a Delegated Services Agreement and upon any amendment to the Delegated Services Agreement or the Vendor Agreement to add services or new products, Health Plan shall determine the capacity of the Vendor's delivery organization to assume responsibility for the activity(ies) proposed to be delegated and to maintain Health Plan standards. This review may include both a document review

and on-site visit. Documents reviewed may include but are not limited to program descriptions, annual work plans, statements of effectiveness, committee minutes and applicable policies and procedures. On-site visits are at the discretion of Health Plan.

III. Annual Evaluation

Annually, Health Plan will conduct an audit of Vendor's ability to provide services in accordance with all Regulatory Requirements. The evaluation may include, but is not limited to, review of Vendor's program descriptions, internal audit review findings, relevant policies and procedures, and as applicable, random sample file reviews, which may include complaints/grievances and case management files,. If the audit findings identify noncompliance with the designated standards, a corrective action plan must be developed as set forth in Section V of this Policy. Vendor shall provide a copy of its policies and procedures and other documents related to performance of its delegated responsibilities to Health Plan on an annual basis upon request.

Vendor and all subcontractors must permit access by all applicable Agencies (including but not limited to the Secretary of Health and Human Services, OIG or their designees) in connection with such Agencies' right to evaluate, through audit, inspection or other means, Vendor's or subcontractors' books, contracts, computers, or any other electronic systems, including medical records and documentation, relating to Health Plan's obligations to such Agencies (e.g., in accordance with federal standards under 45 CFR §156.340(a)), until ten (10) years from the termination date of the Delegated Services Agreement.

Any audit conducted by Health Plan hereunder shall not be deemed to preclude or pre-empt Health Plan's right and ability (i) to access, inspect and/or audit all or any other aspects of Vendor's business or its performance under the Vendor Agreement or Delegated Services Agreement, as contemplated elsewhere in the Vendor Agreement or Delegated Services Agreement, including but not limited to this Policy, or (ii) to collect or assess applicable penalties or fees, or to exercise any remedies provided under the Vendor Agreement or Delegated Services Agreement in connection with the results of any such additional inspection or audit. Vendor acknowledges that the annual evaluation provided for in this Section III of this Policy is limited in its scope, intent and application. Under no circumstances should the conclusions of such audit be construed as applying to files, documents, data or other records not expressly examined in connection with such audit or to any aspect of Vendor's performance outside of the limited scope of such audit. Completion of the annual evaluation set forth in this Section III or any other evaluation or audit (such as the pre-delegation audit) moreover should not be construed as indicating that Vendor is in full compliance with its performance obligations under the Vendor Agreement or Delegated Services Agreement.

IV. Ongoing Monitoring Plan

Vendor shall submit reports to the Health Plan as specified in the exhibits to the Delegated Services Agreement, or on a quarterly or semi-annual basis as required by NCQA Accreditation of Health Plan Standards or other regulatory agencies.

Vendor shall participate in oversight meetings with Health Plan. The meeting may be in-person or telephonic and should occur no less than semi-annually. Oversight activities will be based on Vendor's performance and identified risks. In addition to the oversight reports, special focus will be placed upon

observed trends, the results of actions initiated by the Vendor, and the results of corrective actions taken. Quarterly or more frequent reports may be required from the Vendor if an identified issues requires tracking and monitoring or if the Vendor is placed on a Plan to Cure ("**Plan to Cure**"), Quality Improvement Plan ("**QIP"**) or Corrective Action Plan ("**CAP**") as outlined by Health Plan and as set forth below.

V. Corrective Actions

If Health Plan receives information through its monitoring plan and/or audit processes that Vendor or its subcontractors are not operating in accordance with the Delegated Services Agreement, including this Policy, or any Regulatory Requirements, or are operating in a manner that is hazardous to Covered Persons, or if an Agency requests a CAP from Health Plan due to Vendor's performance, Health Plan will take the following actions:

A. Health Plan will initially request, and Vendor will have ten (10) calendar days to accept the request or request additional clarification. Once any requested clarification is provided:

- For matters involving not operating in accordance with the Delegated Services Agreement, including this Policy, or any Regulatory Requirements, Vendor will, within 14 days, provide, a Plan to Cure, which is a written plan that includes a summary of root causes, actions to mitigate, and member impact analysis.

- For matters involving operating in a manner that is hazardous to Covered Persons, Vendor will provide a Plan to Cure within 3 business days. In the light of clear evidence, Health Plan may determine that hazardous conduct is of such severity that timelines must be restricted to avoid direct health and safety consequences.

For CAP requests Vendor will provide a Plan to Cure within 14 days or the date stipulated by the Health Plan in the event the Health Plan designates a period of time longer than 14 days. The performance issue or noncompliance prompting the Plan to Cure must be resolved within thirty (30) calendar days of the date of Health Plan's request for the Plan to Cure submission or within the negotiated timeframe.

B. If performance issues continue after thirty (30) calendar days or negotiated date, Health Plan can escalate the Plan to Cure by requesting a QIP. Vendor will have thirty (30) calendar days following Health Plan's request to document and provide to Health Plan the terms of a QIP, which is a substantive plan to address Vendor's ongoing performance issues or noncompliance. After the QIP is approved by Health Plan, the actions outlined in the QIP must be completed and the performance issues or noncompliance resolved, within ninety (90) calendar days of Health Plan's approval of the QIP. Vendor must demonstrate sustained performance for at least two (2) consecutive months before the QIP will be closed.

C. If Vendor fails to mitigate the performance issues or noncompliance outlined in the QIP, or if an Agency requests a CAP from Health Plan due to Vendor's performance, Health Plan will request a CAP from Vendor. Vendor will submit the CAP to Health Plan by the date specified. Once Health

Plan or the Agency approves the CAP, all actions in the CAP will be completed within the timeframe specified by Health Plan or the Agency.

D. The CAP shall accomplish the written expected results and such results must be validated by a Health Plan audit within the stated time frame. If the performance issues or noncompliance have not been cured before the expiration of the Plan to Cure, QIP or CAP, or if Vendor or any of its subcontractors fail to comply with this provision, Health Plan may, at its discretion, suspend or revoke the delegation.

E. Health Plan shall cooperate with Vendor or its subcontractors to (i) correct any failure by Vendor to comply with all Regulatory Requirements relating to any matters delegated to Vendor by Health Plan; or (ii) as necessary to ensure Health Plan's compliance with Regulatory Requirements.

F. Health Plan may notify the applicable Agency and request intervention if:

1. Health Plan does not receive a timely response from Vendor as required above; or
2. Health Plan receives a timely response from Vendor as required above, but Health Plan and Vendor are unable to reach an agreement as to whether Vendor:
   a) is complying with the CAP; or
   b) has corrected any problem regarding a practice that is hazardous to Covered Persons.

Health Plan will monitor the Vendor on an ongoing basis to identify opportunities for improvement. At any time, Health Plan may initiate collaborative efforts with Vendor to identify and follow up on opportunities for improvement. Sources for identifying areas for improvement may include but are not limited to: pre-delegation evaluation, annual evaluation, or ongoing reports.

When deficiencies are severe or unable to be resolved, Health Plan reserves the right to withdraw the opportunity for or revoke the delegation arrangement. In addition, CMS and other applicable Agencies reserve the right to revoke the delegated activities and reporting requirements or to specify other remedies in instances where such Agency Health Plan or the Payor determines that Vendor or any subcontractor has not performed satisfactorily.

EXHIBIT B-3
TO DELEGATED SERVICES AGREEMENT
BEHAVIORAL HEALTH CRISIS SERVICES

I. Services.

A. County shall provide the below described Crisis Line Telephone Systems and County Mobile Crisis Intervention Services, including sufficient staffing to meet service delivery requirements outlined in applicable Oregon statutes and regulations, and in this Agreement.

B. County shall provide crisis services for adults, children, adolescents and their families in Clackamas County in accordance with Regulatory Requirements, including as outlined in OAR 309-019-0105, OAR 309-019-0150, Chapter 309, Division 72, and OAR 309-019-0300 through 309-019-0320, and other applicable Oregon statutes and OARs concerning the Services that are in effect on the Effective Date or come into effect during the term of this Agreement, to promote stabilization in a community setting rather than arrest, presentation to an Emergency Department, or admission to an Acute care facility.

C. County shall provide Other Programs as described in this Exhibit.

A. CRISIS LINE TELEPHONE SERVICES

The County will:

1. Provide a dedicated number in place as of the Effective Date of this Agreement.
2. Offer callers the ability for warm transfer, as warranted, to the Health Plan's member services line and community providers.
3. Make available immediate access to trained, skilled, behavioral health professionals located in Oregon, including 24/7 accessibility to a QMHP.
4. Provide 24/7 bi-lingual or interpreter availability.
5. Provide 24/7 telephone screening and triage to determine the need for immediate intervention or Covered Services.
6. Provide 24/7 linkage to emergency service providers, including first responders and mobile crisis services.
7. Provide suicide intervention and prevention services. Lethal means counseling and safety planning for individuals at risk for suicide. Procedures for de-escalation for calls from suicidal individuals.
8. Provide crisis intervention, plan development, and follow-up as indicated.
9. Provide information regarding services and resources in the community.
10. Ensure callers to the Behavioral Health Crisis Line do not at any time receive a busy signal and/or allowed to leave a message and receive a call back.

11. Ensure that an automated response system is never used for Behavioral Health Crisis Line calls.
12. Behavioral Health Crisis Line calls shall not be shifted to an overflow system during times of high call volume.
13. Ensure continuity of operations and back up capability in the event of phone system downtime or emergency.
14. Maintain complete, accurate, and timely documentation of Behavioral Health Crisis Calls and make records for identified Health Plan members available to the Health Plan on a quarterly basis. Written documentation and records shall be in alignment with OAR 309-019-0150(9), 309-019-0305, 309-019-0320, and OAR 309-072-0110, 309-072-140, 309-072-0150, and any additional State reporting requirements.

B. COMMUNITY MOBILE CRISIS INTERVENTION SERVICES

1. The County shall provide Mobile Crisis Intervention Services (MCIS) for adults, children, adolescents and their families in Clackamas County in accordance with the requirements outlined in OARs 309-072-0100 through 309-072-0150, and other applicable Oregon statutes and OARs concerning the Services that are in effect on the Effective Date or come into effect during the term of this Agreement. Community Mobile Crisis Services do not include Stabilization Services described in OAR 309-072-0160. MCIS services shall include, but are not limited to:
    a. 24-hour-a-day, 7-day-a-week capability to provide all necessary services, supports, and treatments for an individual experiencing a behavioral health crisis. Services are to be delivered by County or County's Contracted Providers in a community-based setting and are intended to de-escalate and stabilize an individual in crisis through a timely therapeutic response that meets the needs of the individual in crisis and is individual and family centered. MCIS include, but are not limited to:
        i. An initial response by a two-person Mobile Crisis Intervention Team (MCIT) that includes, at a minimum, a Qualified Mental Health Professional (QMHP) or a trained Qualified Mental Health Associate (QMHA) and one other trained behavioral health provider as defined in OARs 309-072-0100 through 309-072-0150 and OAR 309-019-0125. If a QMHP is not part of the MCIT, a QMHP must be available to respond when clinically indicated, either by telehealth or in person.
        ii. The MCIT carrying or having at least one team member in person trained in administration of naloxone to reverse opioid overdoses.
        iii. The MCIT must be dispatched when requested by 988 call centers in collaboration with the MCIT.
        iv. The initial crisis response shall meet all requirements of OAR 309-072-0150 Initial Crisis Response, including:

A. Following the MCIT's established procedures to ensure safety at the service location for all parties and continue to monitor safety;

B. Documenting all crisis interventions and services offered and provided; attempting to complete a developmentally appropriate suicide screening at every contact;

C. Providing services and supports required under OAR 309-072-0150;

v. Identifying and referring all individuals to appropriate services and supports to meet their needs;

vi. Coordinating care with individual's established provider;

vii. QMHP initiating steps to transport an individual to a psychiatric evaluation if the QMHP determines a director's custody hold is required;

viii. Working collaborative with individuals and families to ensure connect to follow-up services and supports; and

ix. Attempting to follow-up with the individuals and families within 72 hours after the initial contact.

b. Ensuring equitable access to MCIS, particularly for individuals and families who may have faced historical and contemporary discrimination and inequities in health care based on race or ethnicity, physical or cognitive ability, gender, gender identity or presentation, sexual orientation, socioeconomic status, insurance status, citizenship status, or religion.

c. The County or its Contracted Providers will maintain a Certificate of Approval from the OHA for provision of mobile crisis services as required under Regulatory Requirements.

d. Response times by the MCIT to crisis events shall not exceed OHA requirements of maximum response times as defined in OARs 309-072-0100 through 309-072-0150.

e. Maintain complete, accurate, and timely documentation of Mobile Crisis and Mobile Crisis Intervention Services and make records for identified Health Plan members available to the Health Plan on a quarterly basis. Written documentation and records shall be in alignment with OAR 309-072-0110, 309-072-140, 309-072-0150, and any additional Regulatory Requirements.

2. Encounter data. County shall submit encounter data for Mobile Crisis Services or Mobile Crisis Intervention Services provided to Health Plan members by County Providers or Contracted Providers in accordance with encounter requirements as outlined in Exhibit D Oregon Health Plan Product Attachment, the Provider Manual, and other guidance provided by the State, including the MCIS billing guide, available at https://www.oregon.gov/oha/HSD/OHP/Pages/Providers.aspx.

a. County shall submit all MCIS encounter data for services provided in calendar year 2024 no later than April 19, 2025; and for services provided in calendar year 2025, no later than April 13. 2026

b. County shall, no later than one hundred twenty (120) days following the provision of Covered Services, submit encounter data to Trillium in a form and containing such information as Trillium may require.

c. Section 8 "Eligibility Determinations" of the Behavioral Health Services Agreement does not apply to Mobile Crisis Services or Mobile Crisis Intervention Services provided to individuals when the County is unable to obtain information necessary to confirm if the individual is a Trillium Member after attempting to obtain such information as required under OAR 309-072-0140. The County's inability to confirm an individual's eligibility status shall in no way limit the County's provision of Mobile Crisis Services or Mobile Crisis Intervention Services to such individual.

3. Mobile Crisis Settlements. Health Plan is under a risk corridor with OHA. To ensure accuracy of the encounter information Health Plan receives from County and to comply with OHA's requirements for the risk corridor, County shall:

   a. Provide any supporting information requested from Health Plan or OHA for Members receiving treatment for Mobile Crisis to support Health Plan's Mobile Crisis Risk Corridor settlement(s) with OHA, within a reasonable time from Health Plan's request and before Health Plan is required to deliver such information to OHA.

   b. Provide an attestation that MCIS encounters reported by County comply with OAR Chapter 309, Division 72 and any related guidance issued by the State.

   c. Health Plan will receive from OHA a Mobile Crisis Settlement Calculation Form in 2025. When requested by Health Plan, County shall support Health Plan in review of the Mobile Crisis Settlement Calculation Form provided by OHA for the County's services. County shall also provide any additional information reasonably requested by Health Plan as required by OHA or for the Health Plan to validate information on the Mobile Crisis Calculation Form pertaining to the County's services. County shall respond to Health Plan's requests in a timely manner for Health Plan to complete its review and submit a response to OHA within 45 days of Health Plan's receipt of the Mobile Crisis Settlement Calculation Form.

      i. Health plan will submit the completed review to OHA.

      ii. When requested by Health Plan, County shall support Health Plan in any responses to OHA requests for modification or further information on the calculation of Mobile Crisis expenses.

      iii. Health Plan will submit any additional responses to OHA.

      iv. Health Plan shall agree or not agree with OHA's settlement calculation.

   d. Participate in encounter data reconciliation with the Health Plan. County and Health Plan shall review no less than twice annually MCIS encounter data and complete a comparative analysis of Health Plan's encounter data completeness and accuracy by comparing Health Plan's electronic encounter data and the data extracted from the County's data systems. The goal of the comparative analysis is to evaluate the extent to which the encounter data in Health Plan's data warehouse are complete and accurate.

C. Other Programs

1. **Crisis Walk-In Center**. Provide access to Walk-In Center (Behavioral Health urgent care center), 5 days per week. Services provided may include assessment; crisis counseling and education regarding mental health and addiction; peer support; and connection to treatment providers and other social services.
2. **Peer Crisis Support Team.** Include Peers in Crisis Walk-In Center and Community Mobile Crisis Intervention Services, who provide peer support services to individuals for an extended period of time during and after crisis events. If clinically indicated and needed, County will refer to on-going peer resources and provide available materials.

D. General Requirements. In addition to requirements provided elsewhere in this Agreement, the following shall apply to the Services described in this Exhibit [insert #].

1. County shall participate in monthly/quarterly Joint Operating Committee meetings with Health Plan to review County performance of Services in comparison to key contract requirements, community service patterns, current and upcoming system challenges, community training needs, and other identified opportunities for partnership.
2. Reporting. County shall Provide to Health Plan:
    i. Quarterly performance and outcomes reporting relevant to Services as outlined in this Agreement and in support of Health Plan reporting requirements outlined by OHA. Such data shall include counts of Trillium Members, OHP members, and all other members where mutually agreed upon by County and Health Plan.
    ii. Relevant member, provider network, systems & community resources data in support of an efficient and integrated Behavioral Health Crisis Service. Such data shall include counts of Trillium Members, OHP members, and all other members where mutually agreed upon by County and Health Plan.
    iii. Quarterly reporting on crisis services. Such reporting shall include i) total MCIS services provided to individuals who identify as having OHP insurance, including a sub-total of services provided to Trillium identified members, ii) total MCIS services provided to non-OHP members, and iii) any additional summary information mutually agreed upon between the County and Health Plan.
3. Assist the Health Plan in establishing a written Quality Improvement plan for the crisis management system to address the requirements identified in OAR 410-141-3840.
4. Ensure employees, subcontractors and providers are trained in accordance with Regulatory Requirements, including in integration, cultural competency, and Foundations of Trauma Informed Care and provide regular, periodic oversight and technical assistance on these topics to providers.

County responsible to ensure participation of its employees and subcontractors in Health Plan provided training as applicable to their scope of work.

EXHIBIT B-4
TO DELEGATED SERVICES AGREEMENT
WRAPAROUND CARE COORDINATION SERVICES

I. **Services:** County shall provide intensive care coordination services using the fidelity Wraparound model for children and youth with multi-system involvement who are approved for the program by the Wraparound Review Committee. Health Plan and County shall collaborate and participate in the System of Care (SOC) governance.

A. WRAPAROUND SERVICES

The County will:

- Maintain fidelity to the Wraparound model and adhering to the core values and principles described in ORS 418.977.
- Employ Wraparound Facilitators that are trained and maintain fidelity to the Wraparound model.
- Maintaining a ratio of families for each Wraparound Facilitator never greater than fifteen to one (15:1).
    - County shall notify Health Plan if the ratio of members to funded staff approaches 15:1.
- Provide a quarterly registry of members enrolled and a report on the ratio of Wraparound Facilitator to enrolled members.
- Schedule Child and Family team ("CFT") meetings with each enrolled family and child present, to occur at least once every thirty (30) days.
    - Distribute CFT minutes to CFT members and Wraparound facilitator supervisor within five (5) days of meeting.
- Consistently demonstrate Wraparound principles in Provider's documentation and service plans.
- Ensure that the Health Plan participates in the Wraparound Review Committee to screen and accept youth and families into the Wraparound program.
- Ensure that the Wraparound facilitation team:
    - Meet regularly with community organizations for technical assistance and training. Educate and provide technical assistance for community providers and engaged stakeholder agencies on their role in the Wraparound model and process.
    - Meet regularly with Trillium Medical Management Care Coordination to discuss member needs and to coordinate services.
    - Submit team recommendations for behavioral health authorization.
- Complete the Child and Adolescent Needs and Strengths (and any other State report requirements).
- Work with Portland State University to administer a tool to identify, implement and measure fidelity of enhanced wraparound services.
- Educate and provide technical assistance for community providers and engaged stakeholder agencies on their role in the Wraparound model and process.
- Participate as appropriate with local System of Care meetings.
- County will invite the Health Plan to appropriate System of Care meetings.

- Complete wraparound fidelity assessment tools with the CFT as required and provide a copy to Health Plan.
- Participate in monthly/quarterly Joint Operating Committee meetings with Health Plan to review county performance in comparison to key contract requirements, community service patterns, current and upcoming system challenges, community training needs, and other identified opportunities for partnership.
- Submit required quarterly reporting on Wraparound services to the State and Health Plan.
- Share relevant data, information, and reporting to the Health Plan as requested for oversight of Wraparound services.
- Develop and maintain written Wraparound policies and procedures which must include, without limitation:
    - Processes Wraparound Teams must follow when selecting services and supports and identifying those which will require the prior approval of the Providers before receiving such services and supports.
    - Processes Wraparound Teams will be required to follow in order to obtain prior authorization.
- The county will share feedback on the capacity of community services necessary to meet the needs of children and adolescents in Service Area who are eligible to receive Wraparound services.
- Ensure employees are trained in integration, cultural competency, and Foundations of Trauma Informed Care and provide regular, periodic oversight and technical assistance on these topics.
    - County responsible to ensure participation of its employees in Health Plan provided training.

EXHIBIT B-5
TO DELEGATED SERVICES AGREEMENT
CHOICE CARE COORDINATION SERVICES

I. **Services**: County shall provide Choice Model Services to individuals who fall within the scope of Clackamas County, or who are members and individuals assigned to County by OHA to ensure access to services consistent with the clinical needs of the individual and the purpose of the Choice Model Services.

A. Choice Care Coordination

The County will:

- Provide, coordinate and perform all responsibilities for County Choice Model services in accordance with the scope of work outlined in the Intergovernmental Agreement between Clackamas County and the Oregon Health Authority for funding of Choice services.
- Provide exceptional needs care coordination for enrolled Choice participants as follows:
    - Facilitate access to quality individualized community-based services and supports so that adults with SPMI are served in the most integrated setting possible;
    - Provide feedback to the Health Plan on community capacity needs across the service system to meet the clinical needs of enrolled Choice participants.
- Hold a face-to-face meeting with each Individual assigned to Clackamas County being referred to Oregon State Hospitals (OSH) from acute care psychiatric hospitals.
- Hold a face-to-face meeting with each Choice Individual assigned to Clackamas County who is civilly committed, and admitted to OSH within seven calendar days of admission.
- Participate in OSH Interdisciplinary Team (IDT) meetings for each Individual assigned to Clackamas County.
- Coordinate appropriate discharge planning for member.
- Conduct activities to secure and maintain Guardianship Services for Choice members, within available resources.
- Conduct activities that remove barriers and facilitate access to integrated services and supports which are not funded through other sources.
- Develop and maintain written Choice policies and procedures which must include, without limitation, coordination of care with:
    - Choice program contractors,
    - Acute Care Psychiatric Hospitals,
    - Secure Residential Treatment Facilities (SRTF),
    - Oregon State Hospital (OSH) or any other institutional facility,
    - forensic programs for adult members with Severe and Persistent Mental Illness (SPMI).
- Submit quarterly reporting on Choice services to the State and Health Plan.
- Participate in monthly/quarterly Joint Operating Committee meetings with Health Plan to review county performance in comparison to key contract requirements, community

service patterns, current and upcoming system challenges, community training needs, and other identified opportunities for partnership.

- Ensure employees are trained in integration, cultural competency, and foundations of trauma informed care and provide regular, periodic oversight and technical assistance on these topics.
    - County responsible to ensure participation of its employees in Health Plan provided training.

EXHIBIT C

COMPENSATION SCHEDULE

Health Plan shall pay County for Services as described in Exhibit A of this Agreement at the rates per below table. 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.

Service	January 1, 2024-December 31, 2024 Rate	January 1, 2025-December 31, 2025 Rate
PMPM Rates/Services		
1. Behavioral Health Mobile Crisis Services	$2.44 PMPM	$2.54 PMPM
2. Other County administration	$0.483 PMPM	$0.483 PMPM
3. Peer/Community Services	$1.26 PMPM	$1.312 PMPM
TOTAL PMPM	**$PMPM**	

Per Diem Rates/Services	
2. Wraparound Care Coordination	$25.37 per diem
3. Choice Care Coordination	$12.07 per diem

Per diem methodology: total program cost divided by the number of FTEs within the service, divided by the number of calendar days in the year (365), divided by client to staff ratio.

Per diem rates to be paid based on open enrollment in care coordination services as indicated in Health Plan's portal. Per diem rates to be paid for each day a member is assigned by Health Plan to receive County care coordination services. Rate shall be paid regardless of whether member contact occurs. Vendor shall provide to Health Plan on a quarterly basis reporting showing the average number of contacts and service hours per month provided in Vendor's care coordination activities (Wraparound Care Coordination, and Choice Care Coordination) to Trillium members.

Payment Schedule:

- Per Diem Services: County will invoice Health Plan by the 25th day of the month for services performed the prior month. The invoice shall be in the form and shall contain the details mutually agreed to by County and Health Plan ("Complete Invoice"). Payment from Health Plan will be due within thirty (60) calendar days from receipt of the Complete Invoice.

- PMPM Services: Per member Per Month ("PMPM") payments shall be calculated by the Health Plan based on the number of Clackamas County OHP enrollees with CCO plan types CCOA, CCOB, CCOE, and CCOG, eligible and assigned to Trillium on/by the 15th day of each month. Payments shall be made within 60 days of date Health Plan calculates PMPM payments.

Additional Provisions for Covered Services:

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- and encounter 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. 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.

3. Payment under this Compensation Schedule. Encounter data 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.

EXHIBIT D

OREGON HEALTH PLAN PRODUCT ATTACHMENT

TRILLIUM COMMUNITY HEALTH PLAN, Inc. ("**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 Vendors. This Exhibit is incorporated by reference into and made part of the Administrative Services Agreement (the "**Agreement**") with respect to goods and services rendered under the Agreement by Vendor ("**Subcontractor**") to enrollees of Contractor who are enrolled in the Oregon Health Plan managed care program ("**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/HSD/OHP/Pages/CCO-Contract-Forms.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, including Participating Providers that meet the definition of a 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 11, 11.a(1) and 11.a(2)*).

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 4.a(7) and 11.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. 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 11.a(17) and 11.b(1)(b)*)

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 11.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 11.b(1)(d) and 11.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 11.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 11.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 11.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 11.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 11.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 11.b(1)(j)*)

4.9 Pursuant to 42 CFR § 438.608, to the extent Contractor Subcontracts to Subcontractor any responsibility for providing services to Members or processing and paying for claims, Subcontractor will have its own 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 Exhibit B, Part 9 of the OHP Contract, including Section 11.b(8) of such Part. 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 11.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 11.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 17, Exhibit B, Part 8 of the OHP Contract. (*OHP Contract Exhibit B, Part 4, Section 11.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, 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 11.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 (iii) 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' contracts with 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 services being provided, in accordance with OAR 410-141-3565, 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 11.a.11; Part 8, Section 4.g*)

7.2 **Claims Submission.** Pursuant to OAR 410-141-3565, Subcontractor must submit all billings for Members to Contractor within 120 days of the Date of Service. However, Subcontractor

may, if necessary, submit their claims to Contractor within 365 days 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.j*)

7.4 **Eligibility Verification for Fully Dual Eligible Members.** 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*)

7.5 **Payment Eligibility.** Subcontractor understands and agrees that if Contractor is not paid or not eligible for payment by OHA for services provided, neither will Subcontractor be paid or be eligible for payment. (*OHP Contract Exhibit B, Part 4, Section 11.d*)

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 in such a manner as to clearly document Subcontractor's performance. 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).

10.1 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.

10.2 Subcontractor shall, upon request and without charge, provide a suitable work area and copying capabilities to facilitate such a review or audit. This right also includes timely and reasonable access to Subcontractor's personnel for the purpose of interview and discussion related to such documents.

10.3 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.

10.4 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. (*OHP Contract Exhibit D, Section 13*)

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. (*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 124.050 *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 32.b*)

13. **Fraud and Abuse.** Subcontractor will have its own Fraud, Waste, 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 17.d and 17.f*)

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 410-141-3565, 410-141-3570 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 it will use the most current American Society of Addiction Medicine (ASAM) Patient Placement Criteria for the Treatment of Substance-Related Disorders 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 22.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. Subcontractor 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)*

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)*

17. **Americans with Disabilities Act.** In compliance with the Americans with Disabilities Act, 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, Sections 2.b)*

18. **Information/Privacy/Security/Access.** If the Work performed in connection with the OHP Contract permits Subcontractor to have access to or otherwise use of any OHA Information Asset or Network and Information System to which security and privacy requirements apply, and Subcontractor is granted access to such OHA Information Assets or Network and Information Systems, Subcontractor shall comply with the terms and conditions applicable to such access or use and all Applicable Laws and State policies governing use and discloser of Data, including but not limited to Exhibit N of the OHP Contract, and OAR 943-014-0300 through OAR 943-014-0320, as such rules may be revised from time to time. For purposes of this Section, "Data", "Information Asset" and "Network and Information System" have the meaning set forth in Exhibit N of the OHP Contract. (*OHP Contract Exhibit N)*

19. **Governing Law, Consent to Jurisdiction.** The Agreement and the OHP Contract are 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 Clackamas 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)*

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)*

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)*

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)*

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)*

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, Section 4)*

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 21 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, Section 17)*

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 subcontracts 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.

23.1 If Subcontractor Subcontracts any of the Work required under the Agreement and the OHP Contract, Subcontractor shall evaluate and document prospective Subcontractors' readiness and ability to perform the scope of Work set forth in the applicable Subcontract prior to the effective date of the Subcontract. Contractor shall have the right to request, and Subcontractor shall provide within five (5) days after request by Contractor, or sooner if requested by OHA, all readiness review evaluations. If Subcontractor has a contract with Contractor to provide services for a Medicare Advantage plan operated by Contractor or its parent company or subsidiary, Subcontractor may satisfy the requirements of this paragraph 23.1 by submission of the results of its Subcontractor readiness review evaluation required by Medicare, but only for Work identical to that to be Subcontracted under this Agreement and only if the Medicare readiness review has been completed no more than six (6) months prior to the effective date of the prospective Subcontract. (*OHP Contract Exhibit B, Part 4, Sections 11.a.1 and Section 11.a.4*)

23.1 Certified Minority-owned, Woman-owned, or Emerging Small Business (MWESB). Contractor shall maintain an active identification, verification and recruiting process with the goal of expanding MWESB-certified Subcontractors. Contractor shall provide guidance and direction to Subcontractors seeking certification to include identifying resources needed for such Subcontractors to achieve certification. Contractor shall take reasonable steps, such as through a quote, bid, proposal, or similar process, to ensure that Oregon's MWESB-certified firms are provided an equal opportunity to compete for and participate in the performance of any subcontracts under this Agreement. If there may be opportunities for subcontractors of Subcontractors to work on the Agreement, it is the expectation of Contractor that the Subcontractor will take reasonable steps to ensure inclusion, participation, and selection of MWESB-certified firms. (*OHP Contract Exhibit B, Part 4, Section 12*)

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 23*)

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 (PPACA), (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. (*OHP Contract Exhibit E, Section 5.a*)

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. (*OHP Contract Exhibit E, Section 5.b*)

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. (*OHP Contract Exhibit E, Section 5.c*)

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.d*)

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. (*OHP Contract Exhibit E, Section 5.e*)

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. (*OHP Contract Exhibit E, Section 5.f*)

g. The prohibitions in Paras. (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. (*OHP Contract Exhibit E, Section 5.g*)

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.h*)

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://sharedsystems.dhsoha.state.or.us/forms/, Form number ME2090 Notice of Privacy Practices, or may be obtained from OHA. (*OHP Contract Exhibit E, Section 6.a*)

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 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 Privacy Compliance Officer in OHA's Information Security and Privacy Office (ISPO) at DHS.PrivacyHelp@dhsoha.state.or.us with a follow-up telephone call to ISPO's Privacy Reporting Line at 503-945-5780. (*OHP Contract Exhibit E, Section 6.b*)

c. Data Transactions Systems. Subcontractor shall comply with the HIPAA standards for electronic transactions published in 45 CFR Part 162 and the OHA Electronic Data Transmission

Rules, OAR 943-120-0100 through 943-120-0200. 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. (*OHP Contract Exhibit E, Section 6.c*)

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.d*)

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 Laws 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; OAR 410-120-1380*)

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 Subcontractor'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 5.e*)

26.10. Criminal Background Checks. Subcontractor will require its employees to undergo and pass a criminal background check prior to starting any work or services identified in the Agreement; (*OHP Contract Exhibit B, Part 4, Section 11.a(6)*)

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 (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.

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, Section 13.a*)

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. (*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 18.o*)

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 negotiated Claim before any other entity, including Subcontractor, may be paid. In addition, if a Third Party Payer has reimbursed Subcontractor, or its Participating Providers, or its Subcontractors, 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 18.r,18.s, and 18.t*)

29.3. Confidentiality in Recovery Actions. When engaging in Personal Injury 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 18.v*)

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.

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 18.u*)

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(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 18.t*)

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 17.n*)

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 and any of Subcontractor's contracted Providers 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 410-141-3515 and 410-141-3860. Covered Services will be made available when services are provided to any other client for the same services and medically appropriate. This requirement includes the offering of hours of operation to Members that are not less than the hours of operation offered to non-Members as provided in OAR 410-141-3515(*OHP Contract Exhibit B, Part 4, Sections 2.a, 2.d and 11.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, Section 2.j*)

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) have the opportunity to execute a statement of wishes for treatment, including the right to 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 179.505 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, Subcontractors, Participating Providers, or OHA treat the Member. Subcontractor shall not

discriminate in any way against Members when those Members exercise their rights under the OHP. (*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 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*)

33.1 Subcontractor shall comply with Contractor's OHA-approved written procedures for Contractor's Grievance and Appeal System. Subcontractor shall provide copies of the same written procedures to every Provider contracted by the Subcontractor. (*OHP Contract Exhibit B, Part 4, Section 11.a.12*)

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.d*)

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 5.h*)

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 and 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 5.c*)

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(16)*)

40. **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.

41. **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 11.b(2)*)

42. **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 6.c*)

43. **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 8.a(3)*)

44. **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 OAR 410-120-1280 relating to when a Provider may bill a Medicaid recipient and when a Provider may send a Medicaid recipient to collections for unpaid medical bills. ((*OHP Contract Exhibit B, Part 8, Section 4.f*)

45. **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 24.g 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 Section 24*)

46. **Equal Access.** Subcontractor shall provide equal access to Covered Services is provided 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, Section 30*)

47. **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, Section 31*)

48. **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.

48.1 Subcontractor shall comply, and require its Participating Providers to comply, with all protective services, investigation and reporting requirements described in any of the following laws:

(1) OAR Chapter 407, Divisions 45 to 47 (abuse investigations by the Office of Training, Investigations and Safety [OTIS]);
(2) ORS 430.735 through 430.765 (abuse reporting for adults with mental illness or developmental disabilities, including adults receiving services for a substance use disorder or a mental illness in a residential facility or a state hospital);
(3) ORS 124.005 to 124.040 (elderly persons and persons with disabilities abuse);
(4) ORS 441.650 to 441.680 (residents of long term care facilities); and
(5) ORS 418.257 to 418.259 (child in care of a Child-Caring Agency, residential facilities for children with intellectual/developmental disabilities and child foster homes)

48.2 Subcontractor shall report suspected Adult Abuse, neglect or financial exploitation as follows:

(1) Adults with developmental disabilities to the local county developmental disability program;
(2) Adults with mental illness to the local county mental health program;
(3) Patients of the Oregon State Hospital or residents of Substance Use Disorder treatment facilities to DHS OTIS;
(4) Elder Abuse to the local DHS Aging & People with Disabilities office or Area Agency for Aging;
(5) Nursing facility residents to the DHS Nursing Facility Complaint Unit; or
(6) Or by calling 1-855-503-SAFE (7233). This toll-free number allows a report of abuse or neglect of any child or adult to be reported to DHS.
(*OHP Contract Exhibit D, Section 32*)

49. **Behavioral Health Screening; Reporting.** Subcontractor will require its Participating Providers to do all of the following: (a) Use a comprehensive Behavioral Health Assessment tool, in accordance with OAR 309-019-0135, to assist in adapting the intensity and frequency of Behavioral Health services to the Behavioral Health needs of the Member (b) 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); (c) screen Members for, and provide, Medically Appropriate and Evidence-Based treatments for Members who have both mental illness and Substance Use Disorders; (d) 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 (e) 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, 21.g and 22.c*)

50. **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)*

51. **Culturally and Linguistically Appropriate Services (CLAS).** Culturally and Linguistically Appropriate and CLAS each means the provision of effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. (*OHP Contract Exhibit A and Exhibit B Part 4, Section 2)*

51.1 Subcontractor will confirm completion by its Providers, Provider Network, and Provider Network staff of ongoing cultural competency training in accordance with the definition of Cultural Competence (OAR 943-090-0010 and 0020) and the requirements of Cultural Responsiveness and Implicit Bias training per OHP Contract Exhibit K, Section 10.d. Subcontractor shall report on its Cultural Responsiveness and Implicit Bias Training activities to Contractor who, in turn, will incorporate it in its Provider Network reporting. (*OHP Contract Exhibit K, Section 10.d)*

51.2 Interpretation services will be provided by certified or qualified linguistically appropriate interpreters and protect the privacy and independence of members with limited English proficiency (OAR 410-141-3515 (12), *OHP Contract Exhibit B, Part 4 Section 2.h*).

51.3 Per Section 1557 of the Patient Protection and Affordable Care Act requirements, all interpretation and translation services will be free of charge to members and made available at all key points of contact with the Member. Subcontractor is responsible for paying for such services unless otherwise agreed to in the Agreement. Subcontractor shall notify its Providers of the availability of no-cost interpreter services and translation services, including the types of interpreter services available at no cost to the Member, information on how to arrange for interpreter services, and limitations on the use of bilingual staff, minors or accompanying adults as interpreters. (*OHP Contract Exhibit B, Part 3 Section 2.e*)

51.4 Subcontractor shall comply with the requirements of Title II of the Americans with Disabilities Act and Title VI of the Civil Rights Act by assuring communication and delivery of Covered Services to members with diverse cultural and ethnic backgrounds. Such communication and delivery of Covered Services in compliance with such Acts may also require, without limitation, Certified or Qualified Health Care Interpreter services for those members who have difficulty communicating due to a medical condition, disability, or limited English proficiency, or where no adult is available to communicate in English, or there is no telephone and providing access to auxiliary aids and services. Subcontractor must maintain written policies, procedures and plans in accordance with the requirements of OAR 410-141-3515 Network Adequacy. (*OHP Contract Exhibits B, Part 4 Section 2.h)*

51.5 Translated Member materials in non-English threshold languages and alternate formats, including mailed materials and materials available electronically, shall be provided and submitted to the health plan for review and approval. Website and content posted to websites shall meet the accessibility guidelines published by the Web Accessibility Initiative and outlined in Section 508 of the Rehabilitation Act of 1973. All Member materials must be submitted to the Health Plan for review and approval. (*OHP Contract Exhibit B, Part 3 Section 4.d*)

51.6 If applicable, in accordance with OAR 410-141-3875 (11), in those physical, behavioral, and oral health offices where Contractor has delegated responsibilities to Subcontractor for grievance involvement, the Subcontractor shall inform Members of right to file grievance and ensure members receive information regarding a Member's right to file a grievance and seek an independent medical review in threshold, concentration standard languages, and in alternative formats and other languages, upon request. (*OHP Contract Exhibits B, Part 4 Section 2.h, Exhibit K Section 10.d.(6))*

Financial Assistance Application Lifecycle Form

Use this form to track your potential award from conception to submission.

Sections of this form are designed to be completed in collaboration between department program and fiscal staff.

If renewal or direct appropriation, complete sections I, II, IV & V only. Section III is not required.

If Disaster or Emergency Relief Funding, EOC will need to approve prior to being sent to the BCC

CONCEPTION*

Section I: Funding Opportunity Information - To Be Completed by Requester

Award type: Direct Appropriation (no application) / Subrecipient Award / ☑ Direct Award

Award Renewal? ☑ Yes No

Lead Fund # and Department:	240 - H3S-Behavioral Health
Name of Funding Opportunity:	Behavioral Health Services Agreement

Funding Source: Federal – Direct / Federal – Pass through / ☑ State / Local

Requestor Information: (Name of staff initiating form)	Elise Thompson
Requestor Contact Information:	EThompson@clackamas.us; 503-742-5353
Department Fiscal Representative:	Allie Alexander, AAlexander@clackamas.us; 503-742-5335
Program Name & Prior Project #: (please specify)	Behavioral Health Services - Previous Project #400621412

Brief Description of Project:

Trillium Community Health Plan, Inc. is a Coordinated Care Organization (CCO) contractually obligated to arrange for the provision of managed care services to enrollees in the Oregon Health Plan (OHP) that have either selected or been assigned Trillium as their CCO. Trillium contracts with Clackamas County to provide the following services: Delegated Services, to include, Behavioral Health Crisis Services, Behavioral Health Intensive Care Coordination Services, Wraparound Care Coordination Services, and Choice Care Coordination Services, Peer and Community-Based Services.

Name of Funding Agency: Trillium Community Health Plan, Inc.

Notification of Funding Opportunity Web Address: N/A

OR

Application Packet Attached: Yes ☑ No

Completed By: Angie Russell Date: January 6, 2025

***** NOW READY FOR SUBMISSION TO DEPARTMENT FISCAL REPRESENTATIVE *****

Section II: Funding Opportunity Information - To Be Completed by Department Fiscal Rep

Competitive Application / Non-Competing Application / ☑ Other

Assistance Listing Number (ALN), if applicable:	N/A	Funding Agency Award Notification Date:	December 31, 2024
Announcement Date:	N/A	Announcement/Opportunity #:	N/A
Grant Category/Title	N/A	Funding Amount Requested:	$856,139.30
Allows Indirect/Rate:	Yes	Match Requirement:	No
Application Deadline:	N/A	Total Project Cost:	
Award Start Date:	January 1, 2024	Other Deadlines and Description:	N/A
Award End Date	December 31, 2025		
Completed By:	Allie Alexander	Program Income Requirements:	N/A
Pre-Application Meeting Schedule:	N/A		

Additional funding sources available to fund this program? Please describe:
Division has funding agreements with CareOregon to fund similar behavioral health services to Medicaid Members assigned to CareOregon and Health Share of Oregon.

How much General Fund will be used to cover costs in this program, including indirect expenses?
No General Fund will be used for this program.

How much Fund Balance will be used to cover costs in this program, including indirect expenses?
No fund balance will be used to cover costs of this program.

In the next section, limit answers to space available.

Section III: Funding Opportunity Information - To Be Completed at Pre-Application Meeting by Dept Program and Fiscal Staff

Mission/Purpose:

1. How does the grant/funding opportunity support the Department and/or Division's Mission/Purpose/Goals?

2. Who, if any, are the community partners who might be better suited to perform this work?

3. What are the objectives of this funding opportunity? How will we meet these objectives?

4. Does the grant/financial assistance fund an existing program? If yes, which program? If no, what is the purpose of the program?

Organizational Capacity:

1. Does the organization have adequate and qualified staff? If no, can staff be hired within the grant/financial assistance funding opportunity timeframe?

2. Are there partnership efforts required? If yes, who are we partnering with and what are their roles and responsibilities?

3. If this is a pilot project, what is the plan for sun setting the project and/or staff if it does not continue (e.g. making staff positions temporary or limited duration, etc.)?

4. If funded, would this grant/financial assistance create a new program, does the department intend for the program to continue after initial funding is exhausted? If yes, how will the department ensure funding (e.g. request new funding during the budget process, supplanted by a different program, etc.)?

Collaboration

1. List County departments that will collaborate on this award, if any.

Reporting Requirements

1. What are the program reporting requirements for this grant/funding opportunity?

2. How will performance be evaluated? Are we using existing data sources? If yes, what are they and where are they housed? If not, is it feasible to develop a data source within the grant timeframe?

3. What are the fiscal reporting requirements for this funding?

Fiscal

*1. Are there other revenue sources required, available, or will be used to fund the program? Have they already been secured? Please list **all** funding sources and amounts.*

2. For applications with a match requirement, how much is required (in dollars) and what type of funding will be used to meet it (CGF, In-kind, local grant, etc.)?

3. Does this grant/financial assistance cover indirect costs? If yes, is there a rate cap? If no, can additional funds be obtained to support indirect expenses and what are those sources?

Other information necessary to understand this award, if any.

Program Approval:

Allie Alexander	1/22/2025	Allie Alexander
Name (Typed/Printed)	Date	Signature

***** NOW READY FOR PROGRAM MANAGER SUBMISSION TO DIVISION DIRECTOR****

****ATTACH ANY CERTIFICATIONS REQUIRED BY THE FUNDING AGENCY. COUNTY FINANCE OR ADMIN WILL SIGN****

Section IV: Approvals

DIVISION DIRECTOR (or designee, if applicable)

Elise Thompson — Digitally signed by Elise Thompson Date: 2025.01.22 15:25:54 -08'00'

Name (Typed/Printed) | Date | Signature

DEPARTMENT DIRECTOR (or designee, if applicable)

Denise Swanson — Jan 28, 2025 — Denise Swanson (Jan 28, 2025 10:09 PST)

Name (Typed/Printed) | Date | Signature

FINANCE ADMINISTRATION

Elizabeth Comfort — Jan 28, 2025 — Elizabeth Comfort

Name (Typed/Printed) | Date | Signature

EOC COMMAND APPROVAL ***(WHEN NEEDED FOR DISASTER OR EMERGENCY RELIEF APPLICATIONS ONLY)***

Name (Typed/Printed) | Date | Signature

Section V: Board of County Commissioners/County Administration

(Required for all grant applications. If your grant is awarded, all grant ***awards*** *must be approved by the Board on their weekly consent agenda regardless of amount per local budget law 294.338.)*

For applications $150,000 and below:

COUNTY ADMINISTRATOR	Approved:	Denied:
Name (Typed/Printed)	Date	Signature

For applications up to and including $150,000 email form to BCC staff at CA-Financialteam@clackamas.us for Gary Schmidt's approval.

For applications $150,000.01 and above, email form with Staff Report to the Clerk to the Board at ClerktotheBoard@clackamas.us to be brought to the consent agenda.

BCC Agenda item #: Date:

OR

Policy Session Date:

County Administration Attestation

County Administration: re-route to department at

and

Grants Manager at financegrants@clackamas.us

when fully approved.

Department: keep original with your grant file.