**2025 AMENDMENT**
**to the**
**PARTICIPATING PROVIDER AGREEMENT**

Effective April 1, 2025, the Participating Provider Agreement (the "Agreement") between PacificSource Community Solutions ("Health Plan") and Central Oregon Community Mental Health Programs ("CMHPs" or "Provider") is amended to include the following:

1. New Attachments G and H.
2. New Attachment – Wraparound Addendum
3. Inclusion of **Oregon Health Plan (Oregon Health Authority) Contract Exhibit.**

Except for the changes described herein, the Participating Provider Agreement, and all other Exhibits, remain unchanged.

**IN WITNESS WHEREOF**, the Parties have entered into this Agreement as of the date first set forth above.

| **PACIFICSOURCE COMMUNITY SOLUTIONS** | | **DESCHUTES COUNTY HEALTH SERVICES** | |
|---|---|---|---|
| By: | _____<br>PETER MCGARRY | By: | _____<br>ANTHONY DEBONE, CHAIR |
| | | | _____<br>PATTI ADAIR, VICE CHAIR |
| | | | _____<br>PHIL CHANG, COMMISSIONER |
| Title: | VP PROVIDER NETWORK | Title: | BOARD OF DESCHUTES COUNTY COMMISSIONERS |
| Date: | _____ | Date: | _____ |
| Address: | PO Box 7469<br>Bend, OR 97701 | Address: | 2577 NE Courtney Drive<br>Bend, OR 97701 |

**JEFFERSON COUNTY HEALTH SERVICES**
**BOARD OF COUNTY COMMISIONERS**

By:_____

Name: SETH TAYLOR

Title: COMMISSIONER

Date:_____

**JEFFERSON COUNTY HEALTH SERVICES**
**BOARD OF COUNTY COMMISSIONERS**

By:_____

Name: KELLY SIMMELINK

Title: COMMISSIONER

Date:_____

**JEFFERSON COUNTY HEALTH SERVICES**
**BOARD OF COUNTY COMMISSIONERS**

By:_____

Name: MARK WUNSCH

Title: COMMISSIONER

Date:_____

**PACIFICSOURCE COMMUNITY SOLUTIONS**

By:_____

Name: PETER MCGARRY

Title: VP PROVIDER NETWORK

Date:_____

**CROOK COUNTY HEALTH SERVICES**
**BOARD OF COUNTY COMMISIONERS**

By:_____

Name: SETH CRAWFORD

Title: COUNTY JUDGE

Date:_____

**CROOK COUNTY HEALTH SERVICES**
**BOARD OF COUNTY COMMISIONERS**

By:_____

Name: SUSAN HERMRECK

Title: COUNTY COMMISSIONER

Date:_____

**CROOK COUNTY HEALTH SERVICES**
**BOARD OF COUNTY COMMISIONERS**

By:_____

Name: BRIAN BARNEY

Title: COUNTY COMMISSIONER

Date:_____

**PACIFICSOURCE COMMUNITY SOLUTIONS**

By:_____

Name: PETER MCGARRY

Title: VP PROVIDER NETWORK

Date:_____

## ATTACHMENT G

## RISK MODEL

### 1.0 RISK MODEL.

The 2025 Risk model agreed upon by Health Plan, various primary care providers of St. Charles Medical Group, Mosaic Medical Group, Praxis Medical Group, COIPA, and the Central Oregon Community Mental Health Programs ("CMHP(s)") shall contain the following:

(A) A construct involving two (2) main Coordinated Care Organization (CCO) territories (Central Oregon CCO and Columbia Gorge CCO) and settlements within each CCO for OHP Members, as well as the potential for settlement impacts for CMHPs should CMHPs provide services to OHP Members from the Lane, Marion/Polk, or Portland area CCOs. In the Central Oregon CCO, the separate Health Care Budget (HCB) settlements shall be for those OHP Members who are assigned to primary care providers of (i) St. Charles Medical Group (SCMG) combined with the primary care providers of Mosaic Medical Group (Mosaic), (ii) COIPA, and (iii) Praxis Medical Group. In the Central Oregon CCO, there are some OHP Members who are assigned to primary care providers other than SCMG, Mosaic Medical Group, COIPA, and Praxis, for whom there may be no HCB, and/or no settlement involving CMHPs.

(B) A Hospital Capitation Payment to St. Charles Health System (SCHS) for certain hospital services in the Central Oregon CCO as a component of the separate HCBs, and for which there is a Hospital Capitation Withhold (HCW) which shall be settled for SCMG/Mosaic and SCHS.

(C) Capitated payment for primary care providers of SCMG, Mosaic, COIPA, and Praxis Medical Group for certain primary care services provided to any assigned OHP Members from any CCO, for which there will be no withhold and no independent settlement.

(D) Fee-for-service payment for all other professional services provided by SCMG, Mosaic, COIPA, and Praxis Medical Group for any CCO members not designated as capitated primary care services per (C) above.

(E) Capitated and fee-for-service payment to the CMHPs for services provided as detailed in Attachment H. Fee-for-service payments shall have a Claims Risk Withhold.

(F) Patient-Centered Primary Care Home (PCPCH) and Behavioral Health Integration (BHI) per member per month payments for which primary care providers may qualify.

(G) Payment allocations for (B), (C), (D), (E), and (F) above, and separate HCB settlements for health care expenses to determine Claims Risk Withhold and Surplus returns for SCMG, Mosaic, COIPA, Praxis Medical Group, other providers, Community Mental Health Programs (CMHPs) and Health Plan.

(H) Separate risk models which feature Revenue and Expenses for physical health, behavioral health/Substance Abuse Disorder (SUD), Alcohol/Drug – Residential, and Behavioral Health – Residential services under OHP, paid by the state of Oregon to Health Plan as a global capitation payment, and not otherwise designated as revenue contingent on innovation grants, and the exclusion of Revenue and Expenses in the following OHP categories:

- "Dental Care" premium allocation and expenses.
- "Non-Emergent Medical Transportation" premium allocation and expenses.
- Payments to Central Oregon Health Council (COHC), taxes, adjustments, and premium transfers.

If there are significant fluctuations (+/-10%) in the revenue allocations/adjustments for Dental, NEMT, or taxes/adjustments/premium transfers, Health Plan will discuss such fluctuations with CMHPs as soon as possible to gain a mutual understanding of the fluctuation, and whether it was due to membership fluctuation by benefit category, or some other cause.

(I) Contract terms that are consistent with the Joint Management Agreement (JMA) and JMA budget signed between Health Plan and the COHC which specifies the rules, duties, obligation, limitations on Health Plan margin, "Health Services" allocations, and other obligations and expenses for Health Plan as a CCO for Central Oregon.

(J) Utilization and Process Metrics which specify the return of any HCW, and metrics which specify the return of part of the Surplus and Claims Risk Withhold which may result from health care costs measured against any HCB.

## 2.0 CAPITATION.

**2.1 Hospital Capitation Rate (HCR) paid to SCHS:** The HCR shall be **negotiated as a variable** per member, per month (PMPM) for OHP members with physical health benefits and will fluctuate with membership fluctuations in each Rate Category, consistent with the revenue components listed in Section 1,H above. The HCR and the resulting Hospital Capitation Payment to SCHS may vary as Estimated Earned Net Premium Revenue payments from the state of Oregon to Health Plan increase or decrease, and is a weighted average of the following Central Oregon CCO membership in various benefit categories (which will change each month with membership) and PMPM Capitation Rates specific to each Rate Category as indicated below:

| **Rate Category** |
|---|
| Aid to Blind/Disabled & OAA with Medicare |
| Aid to Blind/Disabled & OAA without Medicare |
| CAF Children |
| ACA Ages 19-44 |
| ACA Ages 45-54 |
| ACA Ages 55-64 |
| PLM, TANF and CHIP Children age < 1 |
| PLM, TANF and CHIP Children age 1-5 |

| |
|---|
| PLM, TANF and CHIP Children age 6-18 |
| Poverty Level Medical Adults (includes pregnancy) |
| TANF (Adults only) |
| BCCP |

**2.2 Hospital Capitation Withhold (HCW):** The Hospital Capitation Payment will have an eight percent (8%) Hospital Capitation Withhold.

**2.3 Hospital Capitation Services:** The following hospital services provided to Central Oregon CCO OHP members will be reimbursed via the Hospital Capitation Payment paid to SCHS for services provided at St. Charles Medical Center – Bend, St. Charles Medical Center – Redmond, St. Charles Medical Center – Prineville, and St. Charles Medical Center – Madras:

- Hospital Inpatient Services, including swing beds and rehabilitation.
- Hospital Outpatient Services, including therapies.
- Home Health/Hospice Services billed by St. Charles Medical Center or its owned entities.

In the event of a significant shift in central Oregon community patterns-of-care that increase or decrease by more than five percent (5%) for inpatient care, outpatient surgery, outpatient care, or the proportion of hospital care provided by out-of-area providers for any twelve-month period compared to a prior twelve-month period, the hospital capitation rate may, upon mutual agreement by SCMG, Mosaic, SCHS, COIPA, CMHPs, and Health Plan, be adjusted to account for such shifts in community patterns-of-care.

Both parties acknowledge the Hospital Capitation Payment is not intended to include reimbursement for behavioral health services funded via behavioral health/SUD Residential or other OHP revenue. In the event of a duplicate payment to SCHS for such services paid under the Hospital Capitation Payment, Health Plan will present such information to all risk model entities to adjust for such duplicate payment.

**2.4 Other Hospital Services:** The following hospital services provided to Central Oregon CCO OHP members will be reimbursed via methods other than the Hospital Capitation Payment:

- Professional Services billed by SCHS professional and hospital-based providers and billed on a CMS 1500 form or UB-04 or other form, which, unless covered under a separate agreement.
- Services provided by and billed under St. Charles Medical Group and St. Charles Family Care.
- Services provided by and billed under Sageview Behavioral Health.

- Inpatient and outpatient Behavioral Health/SUD, Alcohol/Drug – Residential, or Behavioral Health – Residential services funded via OHP's Behavioral Health/SUD, Alcohol/Drug - Residential or Behavioral Health – Residential revenue.

- Inpatient and outpatient Dental Services funded as the Oregon Health Plan and OHA's Dental revenue via dental care providers and Dental Care Organizations (DCOs).

**2.5 Primary Care Capitation Rate.** For services provided by SCMG, Mosaic Medical, COIPA, and Praxis Medical Group who is providing certain primary care services for SCMG, Mosaic, COIPA, and Praxis Medical Group-assigned OHP Members, reimbursement will be made on or around the 15th of every month and shall be negotiated as a variable per member per month.

This Primary Care Capitation rate will be made as a per member per month amount for any Federally Qualified Health Centers or Rural Health Centers, upon identification as such by Health Plan.

This Primary Care Capitation Rate will be applied to the following PCP Adjustment Factors attributed to the individual rate categories, which are:

| Rate Category |
|---|
| Aid to Blind/Disabled & OAA with Medicare |
| Aid to Blind/Disabled & OAA without Medicare |
| CAF Children |
| ACA Ages 19-44 |
| ACA Ages 45-54 |
| ACA Ages 55-64 |
| PLM, TANF and CHIP Children age < 1 |
| PLM, TANF and CHIP Children age 1-5 |
| PLM, TANF and CHIP Children age 6-18 |
| Poverty Level Medical Adults (includes pregnancy) |
| TANF (Adults only) |
| BCCP |

Primary care providers shall submit a claim to Health Plan for every service provided, including capitated primary care services.

**2.6 Covered Services Paid By Primary Care Capitation Rate.**

This Primary Care Capitation Rate, multiplied by the PCP Adjustment Factors, will be considered payment in full for the following CPT code services which are provided by primary care providers for their assigned OHP Members:

| Services | CPT Codes |
|---|---|
| Office Visits | 99202-99205, 99211-99215, 99241-99245 |
| Home Services | 99341-99345, 99347-99350 |
| Other Office Services | 92551, 92552, 93000, 93005, 93010, 93790, 95115-95134, 99000-99002, 99050, 99051, 99053, |

| | |
|---|---|
| | 99056, 99058, 99070, 99080, 99366-99368, 99429, 99441-99443 |
| Minor Surgical Services | 10060, 10061, 10080, 10120, 10140, 10160, 11720, 11721, 11740, 16000, 16020, 17110, 17111, 20550, 20600, 20605, 20610, 30300, 36415, 45300, 45303, 46600, 46604, 51701, 54050, 54055, 54056, 56501, 65205, 65220, 69200, 69210 |

## 3.0 COMPENSATION – ALL OTHER PROFESSIONAL SERVICES.

For non-capitated primary care services and all specialty/ancillary services provided to OHP Members irrespective of primary care provider assignment, SCMG, Mosaic, COIPA, and Praxis Medical Group shall be compensated based on Resource Based Relative Value Scale ("RBRVS") conversion factors or a percentage of the current OHP fee schedule. Payment will be less an established Claims Risk Withhold. On an annual basis, this Claims Risk Withhold will be returned in whole, in part, or not returned, based upon (a) the comparison of paid and incurred claims expenses and other costs, to separate HCBs in Sections 7 of this Exhibit B as well as the performance of quality metrics in Section 7.6, or (b) per the contract of the OHP Member's primary care provider, if other than SCMG, Mosaic, COIPA, or Praxis Medical Group.

### 3.1 Medical Fee For Service.

| SERVICE/PROCEDURE | MAXIMUM ALLOWABLE | CLAIMS RISK WITHHOLD |
|---|---|---|
| **Services listed in the CMS Physicians Fee Schedule:** OHA GPCI Adjusted RVUs for services | conversion factor[1, 2, 3] | 8% |
| **Labor and Delivery:** CPT Codes 59400-59622 | conversion factor[1, 2, 3] | 8% |
| **Laboratory:** Services classified by CMS using OHP Medical-Dental Fee Schedule | % of OHP Allowable[1, 3] | 8% |
| **Anesthesia:** Services classified in the American Society of Anesthesiologists Relative Value Guide | per unit ASA Conversion Factor[4] | 8% |
| **Durable Medical Equipment, Prosthetics, Orthotics and Supplies:** Services listed in the OHP Medical-Dental Fee Schedule | % of OHP Allowable[1, 3] | 8% |
| **Injectables, Vaccines, Immunizations:** Services listed in the OHP Medical-Dental Fee Schedule | % of OHP Allowable[1, 3] | 8% |
| **Services and procedures without an OHP Allowable** | | 8% |

**Note:** Payment will be based upon the lesser of the billed amount or Health Plan negotiated rates in effect at the time the service or supplies are rendered or provided as specified above.

1. Updates to the schedules noted above shall be updated in accordance with OHP.
2. Facility and non-facility RVUs shall be used and determined by the setting in which the service occurs.
3. Health Plan will reimburse based on the rates published as of the date of adjudication.

4. ASA Basic Unit Value and annual updates as defined by the American Society of Anesthesiologists Relative Value Guide. Time units shall be based on fifteen (15) minute increments.

**3.2 Patient Centered Primary Care Home (PCPCH) Program and Behavioral Health Integration**.

Primary care providers may opt into Health Plan's Base or Program Participation PCPCH Program.

## 4.0 ALTERNATIVE PAYMENT MODELS.

**4.1 Pediatric Hospitalist Program.**

SCHS shall be paid per OHP Member, per month, for OHP Members assigned to SCMG, Mosaic, COIPA, and Praxis Medical Group's primary care providers in Central Oregon, to support a Pediatric Hospitalist Program (the "Program"). This amount will be an expense against separate HCBs to support the costs of the Program. Program revenue and costs, including FTE costs, will be reported showing any deficit/surplus. SCHS will provide, no less than quarterly, the accounting for the Program revenue and costs as described above to Health Plan.

**4.2 Provider Incentives for Enhanced Access, Quality Improvement and PCPCH Certification.**

SCMG, Mosaic, COIPA, and Praxis Medical Group shall be paid per OHP Member, per month, for OHP Members assigned to SCMG, Mosaic, COIPA, and Praxis Medical Group. This amount will be an expense against their respective HCBs.

**4.3 Deschutes Stabilization Center.**

Deschutes County shall be paid ninety-three cents ($0.93) per OHP Member, per month, for OHP Members assigned to SCMG, Mosaic, COIPA, and Praxis Medical Group primary care providers in Central Oregon, to support a Deschutes Stabilization Center. This amount will be an expense toward HCBs.

## 5.0 PREMIUM ALLOCATION.

Health Plan and CMHPs have established the following allocation of premium in order to implement the compensation and risk incentive structure:

**5.1 Definitions.** Estimated Earned Net Premium Revenue. Estimated Earned Net Premium Revenue shall consist of those global capitation payments (including adjustments and reconciliations with the state of Oregon) received by Health Plan from the State of Oregon for OHP Members assigned to SCMG's/Mosaic's, COIPA's, and Praxis Medical Group's primary care providers in the Central Oregon CCO for health services under OHP, less premium allocations and/or payments for services in Section 1,H, which include: Dental Care premium allocation and claims paid to DCOs, Non-Emergent Medical Transportation premium allocation and claims paid to NEMT vendors, payments to COHC per the agreement with the COHC, taxes, adjustments, premium transfers, innovation grant revenue, OHA-required Hepatitis C reconciliations with OHA as necessary, and any portion of QIM bonus or QIM withhold retained per agreement with the COHC.

**5.2 Allocation of Estimated Earned Net Premium Revenue.**

After the application of any QDP/GME/MCO/Provider taxes, ACA taxes, OHA-required qualified directed pass-through payments, Health Plan Income Taxes for Medicaid, a payment to fund the COHC in the amount of one percent (1%) of gross premium (not counting pass-through funds), premium transfers for Dual Eligible Medicare premium and excluding: Dental Care premium allocation and claims paid to DCOs, Non-Emergent Medical Transportation premium allocation and claims paid to NEMT vendors, innovation grant revenue, OHA-required Hepatitis C reconciliation adjustments with the OHA/state of Oregon as necessary, and QIM withhold retained per agreement with the COHC, the remaining Estimated Earned Net Premium Revenue will be allocated as follows:

5.2.1 Administration. Eight and sixty hundredths' percent (8.60%) of the remaining Estimated Earned Net Premium Revenue shall be allocated to Health Plan for administration.

5.2.2 Amounts Allocated to the primary care provider HCB. Ninety-one and forty hundredths' percent (91.40%) of the remaining Estimated Earned Net Premium Revenue shall be allocated to the separate HCBs of SCMG/Mosaic, COIPA, and Praxis Medical Group.

## 6.0 ALLOCATIONS AND DISBURSEMENT

### 6.1 Computation of Budget Expenses.

For OHP Members assigned separately to primary care providers of SCMG/Mosaic, COIPA, and Praxis Medical Group, all claims expenses (including Claims Risk Withhold), PMPM fees (including credentialing and any CPC+ expenses), reinsurance/stop loss premium expenses (less recoveries), Pharmacy Expenses (less rebates), Hospital Capitation Payments (including HCW), PCP Capitation Expense, subrogation adjustments, premium/MCO taxes, coinsurance expenses, out-of-area expenses, ancillary expenses, behavioral health/Substance Abuse Disorder (SUD) expenses paid to CMHPs, SCHS and other panel providers, Alcohol/Drug Residential expenses, Behavioral Health – Residential expenses, Health Services and other expenses iterated in the Joint Management Agreement (JMA) and JMA budget between Health Plan and the COHC shall be charged to the separate HCBs based on the day services were actually rendered with the exception of Late Claims, as defined in Section 6.2 below, which shall be charged to the next year's applicable budget.

### 6.2 Disposition of Late Claims.

Late Claims are those claims received, processed, and paid later than four months (120 days) after the close of the contract period. Late Claims will be attributed to the next year's applicable budget.

## 7.0 SETTLEMENT PARAMETERS.

### 7.1 Settlement Parameters for OHP Members.

The following settlement parameters for this Section 7 are intended to approximate financial terms for OHP Members assigned to SCMG/Mosaic's, COIPA's, and Praxis Medical Group's primary care providers. CMHP's role in settlements shall be consistent with the settlement terms of SCMG/Mosaic, COIPA, and Praxis Medical Group, should such settlement terms differ from the terms and percentages otherwise indicated in this Section 7. CMHPs understand and agree to be subject to the settlement terms other primary care provider agreements when CMHPs provide services for OHP Members assigned to non-SCMG/Mosaic, non-COIPA, and non-Praxis Medical Group entities.

**7.2 Time Period.**

Annual Claims Risk Withhold and HCW settlement reports will occur for the 2025 calendar year four months (120 days) after the close of the contract period ending December 31st. Any charges/credits to the applicable budgets that have occurred since the settlement of the previous contract period are accounted for in the settlement of the current period.

**7.3 Claims Risk Withhold Settlement Summary.**

Health Plan shall be responsible for computing, documenting, and reporting an annual Claims Risk Withhold settlement summary. This report shall be submitted approximately five months (151 days) after year-end. In the event of a dispute regarding the accuracy and completeness of the data reported by Health Plan, Health Plan agrees to an audit of the data by an independent third party mutually agreed upon between Health Plan and providers, which shall be at the sole cost and expense of providers.

**7.4 Settlement Sequence – HCW.**

The HCW will be settled consistent with the terms of the agreements between Health Plan and SCHS, SCMG, and Mosaic, which are the only entities sharing in the HCW.

**7.5 Settlement Sequence – HCBs.**

After completion of the HCW settlements, HCBs shall be settled per the agreement between Health Plan and SCMG, Mosaic, COIPA, and Praxis Medical Group, of which the CMHPs may be a part.

## 8.0 GENERAL PROVISIONS.

**8.1 Defined Terms.**

Any terms not otherwise defined herein shall have the meaning set forth in the Participating Provider Agreement.

**8.2 Precedence.**

In the event of any conflict or inconsistency between this Exhibit and the Participating Provider Service Agreement, such conflict or inconsistency shall be resolved by giving precedence first to this Exhibit then the Participating Provider Agreement.

**8.3 Health Services Understanding.**

Health Plan and SCMG and COIPA signed a separate Letter of Understanding in July of 2015 which detailed the appropriate allocation of certain health care expenses as being part of any HCB. Consistent with that understanding, Health Plan (a) has entered into a contract with OHA whereby Health Plan has agreed to manage programs to optimize cost, quality and experience of care for OHP Members, (b) is mandated to operate such programs with auditable reporting requirements, (c) has signed an agreement with OHA (consistent with OHA rules and regulations) which stipulates such program expenses are accounted for outside Health Plan administrative/general expenses and are part of health care expenses which are part of any HCB in this Agreement, and (d) calculates a PMPM expense as a percentage of the CCO global budget, to pay for such Health Services programs.

**8.4 Requirements.**

CMHPs will participate in and attest to performing any applicable (a) data submission activities pertinent to CCO EHR-based incentive metrics, (b) data submission requirements including sending accurate data in time and formats determined by CCO to comply with OHA measure specifications, (c) submitting data to Health Plan on a monthly basis by the 20th of the month and acknowledging reports for the first four months of the calendar year will be provided as early as possible based on the delivery from CMHPs' software vendor, (d) requests for surveys or other information, (e) requests to complete successful CCO data collection/submission activities, and (f) reporting expectations for diabetes, hypertension, depression, tobacco prevalence and BMI. CMHPs acknowledge that submission of these requirements is essential as failure to do so for each EHR-based incentive will lead to failure for each eCQM measure, failure to meet the population threshold required and will cause the entire Central Oregon CCO to fail the measure.

CMHPs will perform patient satisfaction surveys in alignment with PCPCH standard requirements and will share such survey results with Health Plan upon reasonable request.

CMHPs will cooperate with Health Plan on Health Plan's CAHPS Improvement Plans.

CMHPs will allow Health Plan to share individual provider performance information such as quality performance metrics with CCO-contracted providers and Health Councils.

**8.5 Oregon Health Plan/OHA Capitation Administration Regulations.**

In the event of (a) requirements rules, regulations or guidance related to applicable provider capitation payments made by Health Plan to CMHPs, and per Health Plan Exhibit L filing and Medical Loss Ratio filings submitted to OHA, and/or (b) Health Plan's and/or OHA's interpretation of applicability of such requirements, rules, regulations, or guidance and applicability of Health Plan's capitation payment methodology with CMHPs, Health Plan may enact the following:

- A charge commensurate with any OHA recoupment, demand for repayment, charge, tax, or fee, to be charged against any HCB, and/or

- A renegotiation with CMHPs to revert all payment methodologies entailing CMHP's capitation, to a fee-for-service payment methodology.

CMHPs shall cooperate with Health Plan to produce reports for Health Plan and/or OHA that satisfy to Health Plan and OHA discretion, the requirements, rules, regulations, or guidance from OHA related to capitation payments.

**8.6 Oregon Health Plan/OHA Possible Premium Revision / MLR-based repayment to OHA.**

In the event of a revision of premium levels for OHP Members by the state of Oregon/OHA by a net amount deemed by Health Plan to be inconsistent with the 2025 (a) CMHP capitation rate, (b) conversion factors, or (c) hospital capitation rates agreed to in this 2025 amendment to the Agreement, Health Plan will notify CMHPs of such inconsistency in writing, and both parties will enter into a renegotiation of 2025 reimbursement rates in order to achieve consistency with any new Oregon Health Plan/OHA premium levels.

In the event OHA determines Health Plan must pay OHA any sum because the Central Oregon CCO Medical Loss Ratio (MLR), as determined by OHA, does not meet a minimum threshold for the entire population or any benefit-category specific sub populations, Health Plan reserves the right to (a) deduct a pro-rata portion of such repayment from any HCB in Section 7, or (b) make direct investments to increase the MLR and offset such expenses with the settlement, upon communication with CMHPs and the COHC.

**8.7 Health Related Services (Flexible Services and Community Based Health-Related Services).**

Consistent with the Health-Related Services Rule adopted by the OHA (which includes member-level disbursements often called "flexible services", and community-based Health-Related Services, often called "Community Benefit Initiatives") and the Health-Related Services Brief released by the OHA, along with Health Plan policies approved by OHA, Health Plan will make certain disbursements from any HCB from time to time and at Health Plan's discretion. These disbursements are distinct from Health Plan-provided Health Services.

**8.8 Community Health Improvement Plan, Transformation Plan, and Health Council Activities.**

CMHPs will collaborate with Health Plan, the COHC, and other stakeholders in completing a Community Health Assessment (CHA) and a Community Health Improvement Plan (CHIP), and in carrying out activities to implement the CHIP including any recommendation tied to community access studies. CMHPs will collaborate with Health Plan, the COHC, and other stakeholders to carry out the Transformation And Quality Strategies. For purposes of the CHA, CHIP, or Transformation And Quality Strategies, for reporting to the COHC or any of its subcommittees, or for reporting to OHA, Health Plan may share CMHP's utilization, membership numbers, and additional performance data. CMHPs will collaborate with Health Plan and the COHC to meet Transformation and Quality Strategies requirements and participate in Transformation And Quality Strategy projects.

**8.9 Corrective Action Plans**

Health Plan, at its sole discretion and consistent with the expectations of Health Plan by OHA, may determine that CMHP's performance of obligations, duties, and responsibilities under the terms of this Agreement is deficient. In reaching that conclusion, Health Plan may, but is not required to consider third-party audit or other formal review results, peer review results, quality measures, written or oral feedback from members or patients, and any other issues which may be identified by Health Plan. If Health Plan determines CMHP's performance is deficient for any reason, but that such deficiency does not constitute a Material Breach of the terms of this Agreement, Health Plan may institute a corrective action plan ("CAP") subject to internal review. Health Plan will notify CMHPs of the terms of the CAP and will provide a CAP reporting template. Health Plan will supply supporting information/data to CMHPs at that time. CMHPs shall have thirty (30) days to resolve the CAP to Health Plan's satisfaction. Failure to resolve the CAP shall constitute a Material Breach by CMHPs, and Health Plan may terminate this Agreement immediately.

**8.10 Cooperation and Engagement in Quality Improvement Process**.

The COHC voted to support QIM-related positions within Health Plan and area providers. CMHPs agrees to cooperate with the QIM Practice Facilitator, QIM Improvement Coordinator, QIM Program Manager, and the ED Improvement Coordinator to support success on regional quality measures including the QIMS, as well as to engage and cooperate with the Provider Engagement Panel to support quality improvement in the region.

**8.11 Member Assignment**

Health Plan may, at its discretion, assign OHP Members to primary care providers. Revisions to assignment procedures may be made in response to objective data related to quality performance, patient access, patient experience, or in response to other information available to Health Plan.

**Attachment H**

**CCO Fee-for-service and Capitation for Behavioral Health Services**
**Community Mental Health Program for Central Oregon CCO**

**Effective 01/01/2025**

## 1. CMHP Fee-for service and Monthly Capitation Payment

For services provided to OHP Members in the counties where the CMHPs are the designated Community Mental Health Program, Health Plan will reimburse CMHPs for Therapy Services and Assessment Services on a fee-for-service basis and on a capitation PMPM basis for Non-Encounterable Health Care Costs and Program Allocation costs according to the below rate schedule. These expenses will be charged and allocated to the separate Health Care Budgets (HCBs) in Attachment G.

Services provided to OHP Members from other CCOs and other counties for which the CMHP is not the designated Community Mental Health Program, CMHPs shall be reimbursed per a separate agreement for such services.

**Intensive In-Home Behavioral Health Treatment (IIBHT) Deschutes County Health Services:**
CMHP shall provide access to Intensive In-Home Behavioral Health Treatment (IIBHT) services for all eligible OHP Members aged twenty (20) and younger in accordance with OARs 309-019- 0167, 410-172-0650, and 410-172-0695. For Deschutes County, IIBHT services shall be submitted using HCPCS code of H0023 and shall be reimbursed through the below capitation table. The services under H0023 are separate from services billed for Behavioral Health outreach and engagement, for which a CPT code will be designated by Health Plan. Until such a time as an alternative code is identified, CMHP will submit non-billable Behavioral Health Outreach and Engagement (H0023) claims to be attributed to Non-Encounterable Healthcare Services Costs in the capitation portion of this contract.

**Intensive In-Home Behavioral Health Treatment (IIBHT) Jefferson County Health Services and Crook County Health Services:**
CMHP shall provide access to Intensive In-Home Behavioral Health Treatment (IIBHT) services for all eligible OHP Members aged twenty (20) and younger in accordance with OARs 309-019- 0167, 410-172-0650, and 410-172-0695. For Jefferson County and Crook County CMHPs, IIBHT services shall be submitted using HPCPS code H0023 and shall be reimbursed at one hundred percent (100%) of the current OHA allowable, with an eight percent (8%) Claims Risk Withhold to be settled per Attachment G.

**Deschutes Stabilization Center**
Deschutes County's CMHP shall be paid ninety-three cents ($0.93) per OHP Member, per month, for OHP Members assigned to SCMG, Mosaic, COIPA, and other primary care providers in Central Oregon, to support a Deschutes Stabilization Center. This amount will be an expense allocated to the separate HCBs.

| **SERVICE/PROCEDURE** for services provided to OHP Members domiciled in | **MAXIMUM ALLOWABLE** | **CLAIMS RISK WITHHOLD** |
|---|---|---|

| | | |
|---|---|---|
| the county for which the provider of care is the designated Community Mental Health Program | | |
| CPT Codes: 90832, 90834, 90837, 90846, 90847, H0004, H0005, H0016, H0038 | 132% of OHP Allowable[1, 3] | 8% |
| CPT Codes: 90791, 90792, H0001, H0031, H2000 | 170% of OHP Allowable[1, 3] | 8% |
| CPT Codes: Q9991 and Q9992 | 100% of OHP Allowable[1, 3] | 8% |

**Note:** Payment will be based upon the lesser of the billed amount or Health Plan negotiated rates in effect at the time the service or supplies are rendered or provided as specified above.

1. Updates to the schedules noted above shall be updated in accordance with OHP.
2. Facility and non-facility RVUs shall be used and determined by the setting in which the service occurs.
3. Health Plan will reimburse based on the rates published as of the date of adjudication.

**Non-Encounterable services/other billed services, Program Allocation and Mobile Crisis Payment and Definition:**

CMHPs shall provide and report non-encounterable services and system supports. Non-encounterable services and system supports include, but are not limited to: travel, prevention, education and outreach, internal case consultation, co-provided services, outreach and engagement, socialization, and psycho-educational services that are not otherwise encounterable. Payments shall be an expense against the HCBs detailed in Attachment G. Payments for such services and programs shall be as follows:

| | **Non-Encounterable services and all other CMHP-billed services PMPM** | **Program Allocation PMPM** | **Mobile Crisis Allocation PMPM** |
|---|---|---|---|
| Deschutes County Health Services, OHP Members domiciled in Deschutes/Klamath County | $19.23 | $6.82 | $0.01 |
| BestCare OHP Members domiciled in Jefferson County | $16.57 | $10.70 | $0.01 |
| BestCare OHP Members domiciled in Crook County | $16.57 | $10.70 | $0.01 |

## Oregon Health Plan (Oregon Health Authority) Contract Exhibit

In the event that any provision contained in this Exhibit conflicts or creates an ambiguity with a provision in this Agreement, this Exhibit's provision will prevail. Capitalized terms not otherwise defined herein shall have the meaning set forth in the OHA Contract, the Non-Medicaid Contract and/or OHP Bridge-BHP Contract (defined below and collectively referred to herein as "the OHA Contracts"). The parties shall comply with all applicable federal, state ,and local laws, rules, regulations and restrictions, executive orders and ordinances, the OHA Contracts, OHA reporting tools/templates and all amendments thereto, and the Oregon Health Authority's ("OHA") instructions applicable to this Agreement, in the conduct of their obligations under this Agreement, including without limitation, where applicable:

**1.0** Provider must perform the services and meet the obligations and terms and condition as if the Provider is PacificSource Community Solutions ("PCS"). [Exhibit B, Part 4, Section 11(a)]

**2.0** This Agreement is intended to specify the subcontracted work and reporting responsibilities, be in compliance with PCS's contracts with OHA to administer the Oregon Health Plan (the "CCO Contract"), the Non-Medicaid programs (the "Non-Medicaid Contract"), and the Oregon Health Plan Bridge-Basic Health Program Services Contract (the "OHP Bridge-BHP Contract"), and incorporate the applicable provisions of the OHA Contracts. Provider shall ensure that any subcontract that it enters into for a portion or all of the work that is part of this Agreement shall comply with the requirements of this Exhibit. [Exhibit B, Part 4, Section 11(a)]

**3.0** PCS is a covered entity and the Parties agree that they will enter into a Business Associate agreement when required under, and in accordance with, the Health Insurance Portability and Accountability Act. [Exhibit B, Part 4, Section 11(a)]

**4.0** Provider understands that PCS shall evaluate and document Provider's readiness and ability to perform the scope of the work set forth in this Agreement prior to the effective date, and shall cooperate with PCS on that evaluation. Provider further understands that OHA has the right to receive all such evaluations. Provider understands and agrees that PCS may utilize a readiness review evaluation conducted by PCS, or a parent company or subsidiary, in relation to a Medicare Advantage subcontract with Provider if the work in question under both contracts is identical and the evaluation was completed no more than three (3) years prior to the effective date of this Agreement. [Exhibit B, Part 4, Section 11(a)]

**5.0** Provider understands that PCS must ensure that Provider, and its employees, are screened for exclusion from participation in federal programs and that PCS is prohibited from contracting with an excluded Provider, and shall cooperate by providing PCS with information to confirm such screening. [Exhibit B, Part 4, Section 11(a)]

**6.0** Provider understands that PCS must ensure that Provider, and its employees, undergo a criminal background check prior to starting any work or services under this Agreement, and shall cooperate by providing PCS with information to confirm such checks. [Exhibit B, Part 4, Section 11(a)]

**7.0** Provider understands that PCS may not Delegate certain work under the OHA Contracts and that this Agreement does not terminate PCS's legal responsibility to OHA for the timely

and effective performance of PCS's duties and responsibilities under the OHA Contracts. Provider further understands that a breach by Provider of a term or condition in the OHA Contracts, as it pertains to work performed under this Agreement, shall be considered a breach by PCS of the OHA Contracts. Further, Provider understands that PCS is solely responsible to OHA for any corrective action plans, sanctions, or the like, and that PCS is solely responsible for monitoring and oversight of any subcontracted work. [Exhibit B, Part 4, Section 11(a)]

**8.0** Provider understands and agrees that PCS must provide OHA with a list of subcontractors (including any work that Provider further subcontracts) and activities required to be performed under such subcontracts, including this Agreement, and shall include: (i) the legal name of Provider and each direct or indirect subcontractor, (ii) the scope of work and/or activities being subcontracted to each direct or indirect subcontractor, (iii) the current risk level of Provider as determined by PCS based on the level of Member impact of Provider's Work, the results of any previous Provider Performance Report(s), and any other factors deemed applicable by PCS or OHA or any combination thereof (provided, however, that PCS must apply the following OHA criteria to identify a High risk Provider, where Provider shall be considered High risk if the Provider: (a) provides direct service to Members or whose Work directly impacts Member care or treatment, or (b) has one or more formal review findings within the last three (3) years for which OHA or PCS or both has required the Provider to undertake any corrective action, or (c) both (a) and (b) above, (iv) copies of the ownership disclosure form, if applicable for Provider, (v) information about any ownership stake between PCS and Provider, if any, and (vi) an attestation from PCS regarding Paragraphs 3 through 5 above and that this Exhibit exists. [Exhibit B, Part 4, Section 11(a)]

**9.0** Provider understands and agrees that the following obligations may not be Delegated to a third party: (i) oversight and monitoring of Quality Improvement activities, and (ii) adjudication of member grievances and appeals. [Exhibit B, Part 4, Section 11(a)]

**10.0** Provider understands and agrees that Provider must respond and remedy any deficiencies identified in Provider's performance of the work or services to be performed under this Agreement, in the timeframe reasonably determined by PCS. [Exhibit B, Part 4, Section 11(a)]

**11.0** Provider acknowledges and agrees that it may not bill Members for services that are not Covered Services under the OHA Contracts unless there is a full written disclosure or waiver on file, signed by the Member, in advance of the service being provided, in accordance with OAR 410-141-3565. [Exhibit B, Part 4, Section 11(a)]

**12.0** Provider acknowledges receiving a copy of PCS's written procedures for its Grievance and Appeal System, agrees to comply with the requirements therein, and agrees to provide those written procedures to any subcontractors of Provider's services provided hereunder. [Exhibit B, Part 4, Section 11(a); Exhibit I, Section 1(b)(1)]

**13.0** Provider understands and agrees that PCS shall monitor and audit Provider's performance on an ongoing basis and also perform timely, formal reviews of compliance with all obligations under this Agreement for the purpose of evaluating Provider's performance, which must identify any deficiencies and areas for improvement. Provider also understands and agrees to cooperate with PCS in the performance of such ongoing monitoring and review. Further, Provider understands and agrees that the annual report

must minimally include the following: (i) an assessment of the quality of Provider's performance of the work performed pursuant to this Agreement, (ii) any complaints or grievances filed in relation to such work, (iii) any late submission of reporting deliverables or incomplete data, (iv) whether Provider's employees are screened and monitored for federal exclusion from participation in Medicaid, (v) the adequacy of Provider's compliance functions, and (vi) any deficiencies that have been identified by OHA related to Provider's work performed pursuant to this Agreement. Provider understands and agrees that PCS may satisfy these requirements by submitting to OHA the results of a compliance review conducted by PCS, or a parent company or subsidiary, in relation to a Medicare Advantage subcontract with Provider if the work in question under both contracts is identical and the time period for the review is identical or inclusive of the time period for a report under this Agreement. Finally, Provider understands and agrees that PCS shall provide OHA with a copy of each review or an attestation, as provided for in the CCO Contracts. [Exhibit B, Part 4, Section 11(a)-(b)]

**14.0** Provider agrees that it shall be placed under a corrective action plan ("CAP") if PCS identifies any deficiencies or areas for improvement in the ongoing monitoring or annual report and that PCS is required to provide a copy of such CAP to OHA, as well as any updates to the CAP, notification that the CAP was successfully addressed, and notification if Provider fails to complete a CAP by the designated deadline. [Exhibit B, Part 4, Section 11(a)]

**15.0** Provider understands and agrees that PCS has the right to take remedial action, pass down or impose Sanctions, and that PCS intends this Agreement to reflect that PCS has the substantively the same rights as OHA has in the OHA Contracts, if Provider's performance is inadequate to meet the requirements of the OHA Contracts. [Exhibit B, Part 4, Section 11(b)]

**16.0** Provider acknowledges and agrees that, notwithstanding any provision of this Agreement to the contrary, that PCS has the right to revoke delegation of any activities or obligations from the OHA Contracts that are included in this Agreement and to specify other remedies in instances where OHA or PCS determine Provider has breached the terms of this Agreement; provided, however, that PCS shall work with Provider to allow Provider reasonable time to cure any such breach. [Exhibit B, Part 4, Section 11(b)]

**17.0** Provider acknowledges and agrees to comply with the payment, withholding, incentive, and other requirements set forth in 42 CFR §438.6 that is applicable to the work or services performed pursuant to this Agreement. [Exhibit B, Part 4, Section 11(b)]

**18.0** Provider agrees to submit to PCS Valid Claims for services, including all the fields and information needed to allow the claim to be processed, within the timeframes for valid, accurate, Encounter Data submission as required by the OHA Contracts. [Exhibit B, Part 4, Section 11(b)]

**19.0** Provider expressly agrees to comply with all Applicable Laws, including without limitation, all Medicaid laws, rules, regulations, all federal laws, rules, regulations governing Basic Health Programs, and all Oregon state laws, rules, and regulations governing OHP Bridge-Basic Health Program, as well as sub-regulatory guidance and contract provisions. [Exhibit B, Part 4, Section 11(b)]

**20.0** Provider expressly agrees that PCS, OHA, the Oregon Secretary of State, the Center for Medicare & Medicaid Services, the U.S. Health & Human Services, 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 Provider, or of Provider's subcontractor, that pertain to any aspect of the services and activities performed, or determination of amounts payable under the OHA Contracts. Provider agrees that such right shall exist for a period of ten (10) years from the date this Agreement terminates or from the date of completion of any audit, whichever is later. Further, Provider agrees that if PCS, OHA, CMS, or the DHHS Inspector General determine that there is a reasonable possibility of Fraud or similar risk, then OHA, CMS or the DHHS Inspector General may inspect, evaluate, and audit Provider at any time. [Exhibit B, Part 4, Section 11(b)]

**21.0** Provider agrees to make available, for purposes of audit, evaluation, or inspection of its premises, physical facilities, equipment, books, Records, contracts, computer, or other electronic systems relating to its Members. [Exhibit B, Part 4, Section 11(b); Exhibit D, Section 15]

**22.0** Provider agrees to 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 OHA Contracts. [Exhibit B, Part 4, Section 12(b)]

**23.0** Pursuant to 42 CFR §438.608, to the extent this Agreement requires Provider to provide services to Members or processing and paying for claims, Provider agrees to adopt and comply with PCS's Fraud, Waste, and Abuse policies, procedures, reporting obligations, and annual Fraud, Waste, and Abuse Prevention Plan, as well as the obligations, terms and conditions provided in Exhibit B, Part 9 of the OHA Contracts. Further, Provider agrees, unless expressly provided otherwise in the applicable provision, to report immediately to PCS any provider and Member Fraud, Waste, or Abuse ("FWA"), which PCS will report to OHA or the applicable agency, division, or entity. [Exhibit B, Part 4, Section 11(b)]

**23.1** In addition to the preceding paragraph, if Provider provides services to Members or processes and pays for claims, then Provider agrees to comply with Exhibit B, Part 9, Sections 11-18 of the OHA Contracts, related to FWA and compliance activities. [Exhibit B, Part 9, Section 10]

**24.0** Provider agrees to meet the standards for timely access to care and services, as set forth in the OHA Contracts and OAR 410-141-3515, which includes providing services within a timeframe that takes into account the urgency of the need for services. [Exhibit B, Part 4, Section 11(b)]

**25.0** Provider agrees to report promptly to PCS any Other Primary, third-party Insurance to which a Member may be entitled. [Exhibit B, Part 4, Section 11(b)]

**26.0** Provider agrees to request, obtain, and provide, in a timely manner as noted in any PCS TPL Guidebook or upon PCS or OHA request, with all Third-Party Liability eligibility information and any other information requested by PCS or OHA, as applicable, in order to assist in the pursuit of financial recovery. Provider also agrees to enter into any data

sharing agreements required by OHA or its PIL Unit. [Exhibit B, Part 4, Section 11(b); Part 8, Section 17(f)(1); Part 8, Section 18(s)(5)]

**27.0** Provider agrees to document, maintain, and provide to PCS all Encounter Data records that document Provider's reimbursement to federally qualified health centers, Rural Health Centers and Indian Health Care Providers and to provide such documents and records to PCS upon request. [Exhibit B, Part 4, Section 11(c)]

**28.0** Provider understands and agrees that if PCS is not paid or not eligible for payment by OHA for services provided, neither will Provider be paid or be eligible for payment. [Exhibit B, Part 4, Section 11(d)]

**29.0** Provider understands and agrees that PCS will provide a copy of this Agreement to OHA upon OHA's request. [Exhibit B, Part 4, Section 11(e)]

**30.0** In accordance with the OHA Contracts, Provider understands and agrees to comply with the following provisions:

**30.1** Adhere to the policies and procedures set forth in PCS's Service Authorization Handbook. [Exhibit B, Part 2, Section 3(a)]

**30.2** Obtain Prior Authorization for Covered Services, as noted on PCS's website. [Exhibit B, Part 2, Section 3(b)(3)]

**30.3** For preventive Covered Services, report all such services provided to Members to PCS and such services are subject to PCS's Medical Case Management and Record Keeping responsibilities. [Exhibit B, Part 2, Section 6(a)(3)]

**30.4** Ensure that each Member is free to exercise their Member rights, and that the exercise of those rights does not adversely affect the way PCS, its staff, Provider, Participating Providers, or OHA, treat the Member. [Exhibit B, Part 3, Section 2(o)]

**30.5** Adhere to PCS's policies for Provider directories, including updating the information therein. [Exhibit B, Part 3, Section 6(i)]

**30.6** Meet the special needs of Members who require accommodations because of a disability or limited English proficiency. [Exhibit B, Part 4, Section 2(k)]

**30.7** Ensure that all Traditional Health Workers undergo and meet the requirements for, and pass the required background check, as described in OAR 950-060-0070 [Exhibit B, part 4, Section 4(a)(6)]

**30.8** Consistent with 42 CFR §438.106 and §438.230, not bill any Member for Covered Services in any amount greater than would be owed if PCS provided the services directly, and 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. [Exhibit B, Part 8, Section 4(f)]

**30.9** If any of PCS's OHA Contracts are terminated, make available to OHA or another health plan to which OHA has assigned the Member, copies of medical, Behavioral Health, Oral Health, and managed Long Term Services and Supports records,

patient files, and any other information necessary for the efficient care management of Members as determined by OHA, in such format(s) as directed by OHA and provided without expense to OHA or the Member. [Exhibit D, Section 10(c)(6)]

**30.10** Section 1 (Governing Law, Consent to Jurisdiction, 2 (Compliance with Applicable Law), 3 (Independent Contractor), 4 (Representations and Warranties), 15 (Access to Records and Facilities; Records Retention; Information Sharing), 16 (Force Majeure), 18 (Assignment of Contract, Successors in Interest), 19 (Subcontracts), 24 (Survival), 30 (Equal Access), 31 (Media Disclosure), and 32 (Mandatory Reporting of Abuse) of Exhibit D of the OHA Contracts, as if fully set forth herein, for the benefit of both OHA and PCS. [Exhibit D, Section 19]

**30.11** Exhibit E of the OHA Contracts, as if fully set forth herein, for the benefit of both OHA and PCS. [Exhibit E]

**30.12** Exhibit F of the OHA Contracts, as if fully set forth herein, for the benefit of both OHA and PCS. [Exhibit F]

**30.13** If any part of the Grievance process is performed by Provider pursuant to this Agreement, meet the requirements of the OHA Contracts, (i) comply with OAR 410-141-3835 through 410-141-3915 and 42 CFR §438.400 through §438.424, (ii) cooperate with any investigation or resolution of a Grievance by either or both DHS's Client Services Unit and OHA's Ombudsperson as expeditiously as the Member's health condition requires, and (iii) provide the data necessary for PCS to fulfill its reporting obligations to OHA. [Exhibit I, Section 1(e)(10), Section 2(d), Section 10]

**30.14** If Provider is required to collect and submit any demographic data to PCS, then Provider shall include REALD data in that data collection and submission. [Exhibit K, Section 12(b)]

**30.15** Respond promptly and truthfully to all inquiries made by OHA or by the Oregon Department of Consumer and Business Services ("DCBS") concerning any subcontracted work and transactions pursuant to or connected to the OHA Contracts, using the form of communication requested by OHA or DCBS. [Exhibit L, Section 3(a)]

**30.16** If Provider makes any prior authorization determinations for substance use disorder treatment services and supports, then Provider shall ensure its staff have a working knowledge of the ASAM Criteria, as required by the OHP SUD 1115 demonstration waiver. Further, Provider shall confirm compliance with this requirement upon request of PCS, so that PCS can submit an attestation of compliance to OHA. [Exhibit M, Section 7(j)]

**30.17** Provide all required information to PCS necessary for PCS to submit an annual Behavioral Health report to OHA. [Exhibit M, Section 14, 23]

**30.18** Take any PCS required training or otherwise provide training within Provider's operations regarding recovery principles, motivational interviewing, integration, and Foundations of Trauma Informed Care (https://tramainformedoregon.org/tic-intro-training-modules/), and, if applicable, enroll in, and provide timely updates to, OHA's Centralized Behavioral Health Provider Directory. [Exhibit M, Section 24]

**30.19** Exhibit N of the OHA Contracts, as if fully set forth herein, for the benefit of both OHA and PCS. [Exhibit N]

**31.0** Provider agrees to comply with Section C Part 10 of Attachment I of the 2017-2022 Medicaid 1115 Waiver regarding timely Payment to Indian Health Care Providers. [OAR 410-141-3505]

**32.0** Provider acknowledges that it has received a copy of the current version of the OHA Contracts, with the exception of Exhibit C.

**33.0 Miscellaneous.**

**33.1** *Provider Certification.* Provider hereby certifies that all claims submissions and/or information received from Provider are true, accurate, and complete, and that payment of the claims by PCS, or its subcontractor, for PCS Members will be from federal and state funds, and therefore any falsification, or concealment of material fact by Provider when submitting claims may be prosecuted under federal and state laws. Provider shall submit such claims in a timely fashion such that PCS may comply with any applicable Encounter Data submission timeframes and shall include sufficient data and information for OHA to secure federal drug rebates for outpatient drugs provided to PCS's Members under this Agreement, if any. Provider hereby further certifies that it is not and will not be compensated for any work performed under this Agreement by any other source or entity.

**33.2** *Indemnification.* Notwithstanding any indemnification provision in this Agreement, as it pertains to PCS Members, Provider shall defend, save, hold harmless and indemnify PCS, the State of Oregon, and their respective officers, employees, subcontractors, agents, insurers, and attorneys from and against all of the following (here "Indemnifiable Events"): all claims, suits, actions, losses, damages, liabilities, settlements, costs and expenses of any nature whatsoever (including reasonable attorneys' fees and expenses at trial, at mediation, on appeal and in connection with any petition for review) resulting from, arising out of, or relating to the activities of Provider or its officers, employees, subcontractors, agents, insurers, and attorneys (or any combination of them) under this Agreement. Indemnifiable Events include, without limitation (i) unauthorized disclosure of confidential records or Protected Information, including without limitation records and information protected by HIPAA or 42 CFR Part 2, (ii) any breach of this Exhibit or the Agreement, (iii) impermissible denial of Covered Services, (iv) failure to comply with any reporting obligations under this Agreement, and (v) failure to enforce any obligation of a subcontractor under this Agreement.

Provider shall have control of the defense and settlement of any claim this is subject to this Section 33.2; however, neither Provider nor any attorney engaged by Provider, shall defend the claim in the name of the State of Oregon or any agency of the State of Oregon, nor purport to act as legal representative of the State of Oregon or any of its agencies, without first receiving the prior written approval of the Oregon Attorney General to act as legal counsel for the State of Oregon; nor shall Provider settle any claim on behalf of the State of Oregon without the prior written approval of the Attorney General. The State of Oregon may, at its election, assume its own defense and settlement in the event that the State of Oregon determines that Provider is

prohibited from defending the State of Oregon, or is not adequately defending its interests. The State of Oregon may, at its own election and expense, assume its own defense and settlement in the event the State of Oregon determines that an important governmental principle is at issue.

Provider shall ensure that the State of Oregon, Department of Human Services is not held liable for (i) any of Provider's debts or liabilities in the event of insolvency, regardless of whether such liabilities arise out of such parties' insolvency or bankruptcy; (ii) Covered Services authorized or required to be provided by Provider under this Agreement, regardless of whether such Covered Services were provided or performed by Provider, Provider's subcontractor, or Provider's Participating or Non-Participating Provider; or (iii) both (i) and (ii) of this sentence.

Notwithstanding the foregoing, no party shall be liable to any other party for lost profits, damages related to diminution in value, incidental, special, punitive, or consequential damages under this Agreement; provided, however, Provider shall be liable (i) for civil penalties assessed against PCS by OHA related to a breach of this Agreement by Provider; (ii) for Liquidated Damages assessed against PCS by OHA related to a breach of this Agreement by Provider; (iii) under the Oregon False Claims Act; (iv) for Indemnifiable Events as noted above, (v) claims arising out of or related to unauthorized disclosure of confidential records or information of Members (or both of them), including without limitation records or information protected by HIPAA or 42 CFR Part 2; (vi) any OHA expenses assessed to PCS for termination of the OHA Contracts that are related to a breach of this Agreement by Provider; or (vii) damages specifically authorized under another provision of this Agreement. [Exhibit D, Section 8 and 12]

**33.3** *Force Majeure.* Neither OHA, Provider nor PCS shall be held responsible for delay or default caused by riots, acts of God, power outage, fire, civil unrest, labor unrest, natural causes, government fiat, terrorist acts, other acts of political sabotage or war, earthquake, tsunami, flood, or other similar natural disaster, which is beyond the reasonable control of the affected party. Each party shall, however, make all reasonable efforts to remove or eliminate such cause of delay or default and shall, upon the cessation of the cause, diligently pursue performance of its obligations under this Agreement. OHA or PCS may terminate this Agreement upon written notice to Provider after reasonably determining that the delay or default will likely prevent successful performance of this Agreement.

If the rendering of services or benefits under this Agreement is delayed or made impractical due to any of the circumstances listed in the preceding paragraph, care may be deferred until after resolution of those circumstances, except in the following situations: (a) care is needed for Emergency Services; (b) care is needed for Urgent Care Services; or (c) care is needed where there is a potential for a serious adverse medical consequence if treatment or diagnosis is delayed more than thirty (30) days.

If any of the circumstances listed in the first paragraph of this section disrupts normal execution of Provider's duties under this Agreement, Provider shall notify Members in writing of the situation and direct Members to bring serious health care needs to Provider's attention. [Exhibit D, Section 16]

**33.4** *No Third Party Beneficiaries.* PCS and Provider are the only parties to this Agreement and the only parties entitled to enforce its terms; provided, however, that OHA and other government bodies have the rights specifically identified in this Agreement. The parties agree that Provider's performance under this Agreement is solely for the benefit of PCS to fulfill its OHA Contracts obligations and assist OHA in accomplishing its statutory mission. Nothing in this Agreement gives, is intended to give, or shall be construed to give or provide any benefit or right, whether directly, indirectly or otherwise, to third persons any greater than the rights and benefits enjoyed by the general public unless such third persons are individually identified by name herein and expressly described as intended beneficiaries of the terms of this Agreement. This provision shall survive the termination of this Agreement for any reason.

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

**33.6** *Termination; Revocation of Delegated Activities.* Notwithstanding any other provision in this Agreement, PCS may terminate this Agreement or impose Sanctions, as provided in the OHA Contracts, if Provider's performance is inadequate to meet the requirements of the OHA Contracts.

**33.7** *Subcontractor/FDR Manual.* Provider shall comply with the due dates and requirements in PCS's Subcontractor/FDR Manual (the "Manual"), as amended, once that Manual is finalized and posted. Provider is responsible for reviewing the Manual periodically in order to know the current requirements.

**34.0** Differences Between the CCO Contract, the Non-Medicaid Contract, and/or the OHP Bridge-BHP Contract. There are a few language differences between the CCO Contract, the Non-Medicaid Contract, and OHP Bridge-BHP. To the extent that Provider only works with one population or the other, that contract will apply; however, to the extent that Provider works with one or more populations, all relevant contracts will apply, as applicable, to the situation depending on what work and what population is involved.

**35.0** If Provider is also a HRSN Service Provider, then Provider understands and agrees that it is prohibited from having any involvement in (i) authorizing or denying any HRSN Service or (ii) service planning for an HRSN Eligible Member. [HRSN Amendment #24, Section 16(i)(3)]

**36.0** Provider agrees and acknowledges that the OHA periodically amends the OHA Contracts. Provider also agrees and acknowledges that PCS may periodically send an updated version of this Exhibit that will automatically replace this Exhibit and be incorporated into Provider's contract with PCS.