POLK COUNTY BOARD OF COMMISSIONERS

DATE: January 29, 2025
TIME: 9:00 a.m.
PLACE: Polk County Courthouse, Dallas, Oregon

THE LOCATION OF THIS MEETING IS ADA ACCESSIBLE. PLEASE ADVISE THE BOARD OF COMMISSIONERS AT (503-623-8173), AT LEAST 24 HOURS IN ADVANCE, OF ANY SPECIAL ACCOMMODATIONS NEEDED TO ATTEND OR TO PARTICIPATE IN THE MEETING VIRTUALLY.

PAGE: **AGENDA ITEMS**

1. CALL TO ORDER AND NOTE OF ATTENDANCE

2. ANNOUNCEMENTS

   (a) Regular meetings of the Board of Commissioners are held on Tuesday and Wednesday each week. Each meeting is held in the Courthouse Conference Room, 850 Main Street, Dallas, Oregon. Each meeting begins at 9:00 a.m. and is conducted according to a prepared agenda that lists the principal subjects anticipated to be considered. Pursuant to ORS 192.640, the Board may consider and take action on subjects that are not listed on the agenda. The Board also holds a department staff meeting at 9:00am on every Monday in the Commissioners Conference Room at 850 Main Street, Dallas, Oregon.

   (b) The Polk County Board of Commissioners will be attending the Polk County Local Public Safety Coordinating Council meeting on February 3, 2025 at 12:00 p.m., located at 850 Main St., Dallas, OR 97338.

3. COMMENTS (for items not on this agenda and limited to 3 minutes)
4. APPROVAL OF AGENDA
5. APPROVAL OF THE MINUTES FROM January 22, 2025
6. APPROVAL OF CONSENT CALENDAR
7. POLK COUNTY MONTHLY TREASURER REPORT – Steve Milligan
8. POLK COUNTY ORDINANCE NO. 25-01 – Morgan Smith

CONSENT CALENDAR

a) Polk County Resolution No. 25-02, Polk County Rules Revisions
Matt Hawkins, Admin Services Director)

b) Polk County Resolution No. 25-04, To Correct Resolution No. 25-03
(Greg Hansen, Administrative Officer)

c) Polk County Order No. 25-02, Appointing a Local Public Health Administrator
(Morgan Smith, County Counsel)

d) Polk County Ordinance No. 25-02, Modifying Chapter 15
(Morgan Smith, County Counsel)

e) Polk County Contract No. 25-12, PacificSource Community Solutions
(Rosana Warren, Health Services)

THE BOARD OF COMMISSIONERS WILL MEET IN EXECUTIVE SESSION PURSUANT TO ORS 192.660.

ADJOURNMENT

POLK COUNTY PUBLIC MEETINGS AND PUBLIC HEARINGS
GUIDELINE FOR CITIZENS

****

REGULAR MEETING AGENDA

Regular meetings of the Polk County Board of Commissioners convene at 9 a.m. each Wednesday morning. Any person wishing to bring a matter before the Board at one of these meetings may do so by mailing or delivering written notice, concisely describing the nature of the item, to the Board of Commissioners, Polk County Courthouse, Dallas, Oregon 97338, by noon on the preceding Thursday. Unless otherwise announced, meetings are held in the Main Conference Room of the Courthouse.

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APPEARANCE OF INTERESTED CITIZENS

The Board sets aside a time at each regular meeting for comment by the public on subjects not appearing on the Agenda. Individuals may come forward and make any statement they wish, but not to exceed three (3) minutes in length, except as is required to give concise answers to questions from Board members. If the subject will require a lengthier presentation, or merits inclusion as an item on the Agenda of a future meeting, the Board shall schedule it accordingly.

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PUBLIC HEARING FORMAT
Land Use

1. Chairman opens hearing.
   a. Reading of hearing request or appeal statement.
   b. Call for abstentions (ex parte contact or conflict of interest).
2. County staff presents background, summary and its recommendation (20-minute limit).
3. Applicant (Appellant) presents his/her case (15-minute limit).
4. Public testimony. Note that all testimony and evidence must be directed toward the applicable factual and legal criteria as identified in the record and/or during this hearing. Do not repeat previous testimony. Simply note for the record that you are in agreement with that earlier testimony. Your time to present testimony is limited. FAILURE TO RAISE AN ISSUE IN THIS HEARING, IN PERSON OR BY LETTER, OR FAILURE TO PROVIDE ADEQUATE SPECIFICITY TO AFFORD THE BOARD AN OPPORTUNITY TO RESPOND TO THE ISSUE MAY PRECLUDE LATER APPEAL TO LUBA ON THAT ISSUE.
   a. Individuals in favor of the application or appeal.
   b. Individuals against the application or appeal. At the discretion of the Chairman, an attorney, consultant, or other designated representative of two or more individuals may be allowed the combined time for each represented individual who does not speak, not to exceed 20 minutes. The Chairman may require proof of designation.
5. Rebuttal by Applicant (Appellant) (10-minute limit).
6. Questions from Board (discussion limited to individuals questioned by the Board).
   a. Staff.
   b. Applicant (Appellant).
   c. Individuals testifying.
7. Chairman closes hearing and announces closing of Record.
8. Chairman announces date for deliberation and decision.
9. The Board's decision is deemed the final decision of Polk County. It may be appealed to LUBA within 21 days of its issuance in written form. The address and phone number of LUBA may be obtained from the Polk County Community Development Department and will also appear on the Notice of Decision which will be mailed to all persons who testify, submit comments, or print their name and address on the hearing attendance sheet at the back of the hearing room.

POLK COUNTY BOARD OF COMMISSIONERS
MINUTES January 22, 2025

1. CALL TO ORDER & ATTENDANCE

At 9:00 a.m., Commissioner Pope declared the meeting of the Polk County Board of Commissioners to be in session. Commissioner Mordhorst was present and Commissioner Gordon was absent.

Staff present: Greg Hansen, Administrative Officer
Morgan Smith, County Counsel
Matt Hawkins, Administrative Services Director

2. ANNOUNCEMENTS

Regular meetings of the Board of Commissioners are held on Tuesday and Wednesday each week. Each meeting is held in the Courthouse Conference Room, 850 Main Street, Dallas, Oregon. Each meeting begins at 9:00 a.m. and is conducted according to a prepared agenda that lists the principle subjects anticipated to be considered. Pursuant to ORS 192.640, The Board may consider and take action on subjects that are not listed on the agenda. The Board also holds a department staff meeting at 9:00 a.m. on every Monday in the Commissioners Conference Room at 850 Main Street, Dallas, Oregon.

The Polk County Board of Commissioners will be attending the Polk County Local Public Safety Coordinating Council meeting on February 3, 2025 at 12:00 p.m., located at 850 Main St., Dallas, OR 97338.

3. COMMENTS

None.

4. APPROVAL OF AGENDA

MOTION: COMMISSIONER MORDHORST MOVED, COMMISSIONER POPE SECONDED, TO APPROVE THE AGENDA.

MOTION PASSED BY VOTE OF THE QUORUM.

5. APPROVAL OF MINUTES OF January 15, 2025

MOTION: COMMISSIONER MORDHORST MOVED, COMMISSIONER POPE SECONDED, TO APPROVE THE MINUTES OF January 15, 2025.

MOTION PASSED BY VOTE OF THE QUORUM.

6. APPROVAL OF CONSENT CALENDAR

MOTION: COMMISSIONER MORDHORST MOVED, COMMISSIONER POPE SECONDED, TO APPROVE THE CONSENT CALENDAR.

MOTION PASSED BY VOTE OF THE QUORUM.

7. RECLASSIFICATION OF AN EMPLOYEE

Matt Hawkins, Admins Services Director, is recommending the reclassification of a Payroll Clerk to a Payroll Clerk II. Should the reclassification be approved, it would be effective February 1, 2025 and have an approximate fiscal impact on the FY24-25 budget of $3,200 including PERS contribution, should it be for 12 months.

APPROVED BY CONSENSUS OF THE QUORUM.

8. POLK COUNTY FAIRGROUNDS OPERATING LEVY & RESOLUTION NO. 25-03

Greg Hansen, Administrative Officer, presented a memorandum along with Polk County Resolution No. 25-03 to the Board. Mr. Hansen provided background information and explained why he is recommending that the Board approve and sign resolution no. 25-03 today. Mr. Hansen stated that before Commissioner Gordon was out this week, he stated his full support for this resolution.

MOTION: COMMISSIONER MORDHORST MOVED, COMMISSIONER POPE SECONDED, TO APPROVE AND SIGN RESOLUTION NO. 25-03.

MOTION PASSED BY VOTE OF THE QUORUM.

The following items were approved by Motion under **5. APPROVAL OF CONSENT CALENDAR:**

a) Polk County Contract No. 25-08, Perrydale School District
(Jennifer Segovia, Family & Community Outreach)

b) Polk County Order No. 25-02, in the matter of imposing speed restrictions
On Black Rock Road
(Todd Whitaker, Public Works Director)

There no need for an executive session and Commissioner Pope adjourned the meeting at 9:05 a.m.

POLK COUNTY BOARD OF COMMISSIONERS

Craig Pope, Chair

Jeremy Gordon, Commissioner

Lyle Mordhorst, Commissioner

Minutes: Nicole Pineda
Approved: January 29, 2025

BEFORE THE BOARD OF COMMISSIONERS
FOR THE COUNTY OF POLK, STATE OF OREGON

In the Matter of Adopting an Ordinance to	)
Establish the Office of County Accountant	)
	)
	)

ORDINANCE NO. 25-01

WHEREAS, ORS 210.010 allows the governing body of any County to create the Office of County Accountant.

THE POLK COUNTY BOARD OF COMMISSIONERS ORDAINS AS FOLLOWS:

Section 1. Enactment. Pursuant to ORS 210.010 Polk County Board of Commissioners hereby establishes the Office of the County Accountant.

Section 2. Appointment. Pursuant to ORS 210.120, the Polk County Board of Commissioners appoints Katlyn D'Agostini to serve as the County Accountant. Ms. D'Agostini shall qualify for this position pursuant to the requirements of ORS 210.120 by executing a bond in the sum of $20,000.00 with the necessary requirements outlined by statute and taking a oath of office with the Polk County Clerk within thirty (30) days of this Ordinance's effective date.

Section 3. Duties. The Office of the County Accountant shall perform all necessary tasks and responsibilities outlined in ORS Chapter 210 and all other laws applicable to the function of a County Accountant.

Section 4. Severability. Should any section or portion of this ordinance be held unlawful or unenforceable by any court of competent jurisdiction, such decision shall apply only to the specific section, or portion thereof, directly specified in the decision. All other sections or portions of this ordinance shall remain in full force and effect.

Dated this 29th day of January, 2025 at Dallas, Oregon.

POLK COUNTY BOARD OF COMMISSIONERS

_____
Craig A. Pope, Chair

_____
Lyle Mordhorst, Commissioner

_____
Jeremy Gordon, Commissioner

Approved as to Form:

_____
County Counsel

First Reading: _____

Second Reading: _____

Recording Secretary: _____

POLK COUNTY

HUMAN RESOURCES

POLK COUNTY COURTHOUSE ★ DALLAS, OREGON 97338-3174
(503) 623-1888 ★ FAX (503) 623-1889

MEMORANDUM

TO: Board of Commissioners

FROM: Matt Hawkins, Admin. Services Director

DATE: January 14, 2025

SUBJECT: Adopt Resolution No. 25-02

Wednesday – January 29, 2025 (Consent)

RECOMMENDATION:

The Board of Commissioners adopt Resolution No. 25-02.

ISSUE:

Shall the Board approve this Resolution?

DISCUSSION:

Employee input has been sought, a public meeting has been conducted, and County Counsel, the Administrative Officer and the Commissioners have all reviewed the recommended revisions Human Resources has made to the Polk County Personnel Rules. Resolution 25-02 has been prepared and is ready to be signed by the Polk County Board of Commissioners.

FISCAL IMPACT:

There is no anticipated fiscal impact.

BEFORE THE BOARD OF COMMISSIONERS FOR POLK COUNTY, OREGON

In the Matter of)
Personnel Rules Amendments)

RESOLUTION NO. 25-02

WHEREAS, the Polk County Code Section 11.110 requires the Board of Commissioners annually to review the Polk County Personnel Rules; and

WHEREAS, the Board has disseminated proposed amendments for review and comment by County employees per Rule 2.1.1, Development of Rules; and

WHEREAS, the Board reviewed the Polk County Personnel Rules on January 21, 2025 as required by Polk County Code Section 11.110; and

WHEREAS, the Board conducted a public meeting on September 26, 2023 on amendments to the rules listed in Appendix A, a copy of which is attached hereto and incorporated by reference herein, as required by Polk County Code Section 11.115; now, therefore:

THE POLK COUNTY BOARD OF COMMISSIONERS RESOLVE:

The Polk County Personnel Rules are revised in the manner set out in Appendix A of this resolution.

DATED January 29, 2025 Dallas, Oregon.

POLK COUNTY BOARD OF COMMISSIONERS

_____
Craig Pope, Chairman

_____
Jeremy Gordon, Commissioner

_____
Lyle Mordhorst, Commissioner

Approved as to Form:

_____
Morgan Smith
County Counsel

BEFORE THE BOARD OF COMMISSIONERS
FOR POLK COUNTY, OREGON

In the Matter of Correcting Resolution No. 25-03	))))

RESOLUTION NO. 25-04

WHEREAS, the Polk County Board of Commissioners adopted Resolution 25-03 regarding submitting a local option tax to the voters of the County; and

WHEREAS, Resolution 25-03 contained scrivener's errors that require correction; now therefore,

IT IS HEREBY RESOLVED that the Board of Commissioners, County of Polk, adopt this resolution to correct Resolution 24-03. All references to the May 13, 2025 election contained in Resolution 25-03 shall be replaced by the date of May 20, 2025. All other provisions of Resolution 25-03 shall remain in full force and effect.

Dated this 29th day of January, 2025 at Dallas, Oregon.

POLK COUNTY BOARD OF COMMISSIONERS

_____
Craig Pope, Chair

_____
Jeremy Gordon, Commissioner

_____
Lyle Mordhorst, Commissioner

Approved as to Form:

_____
Morgan Smith, County Counsel

Request for Ballot Title

Preparation or Publication of Notice

SEL 805
rev 08/21
OAR 165-014-0005

No later than the **81st day before an election**, a governing body that has referred a measure must prepare and file with the local elections official the text of the referral for ballot title preparation or the ballot title for publication of notice of receipt of ballot title. This form may be used to file the text of the referral and request the elections official begin the ballot title drafting process or file a ballot title and request the elections official publish notice of receipt of ballot title.

Filing Information

Election Date	Authorized Official
May 20, 2025	Greg Hansen, Administrative Officer
Contact Phone	**Email Address**
503-623-8173	hansen.greg@co.polk.or.us

Referral Information

Title, Number or other Identifier
Polk County Fairgrounds & Event Center Local Option Tax

This Filing is For

☐ Drafting of Ballot Title Attach referral text.
■ Publication of Notice Ballot title below.

Ballot Title Additional requirements may apply

Caption 10 words which reasonably identifies the subject of the measure.
Polk County Fairgrounds & Event Center Local Option Tax

Question 20 words which plainly phrases the chief purpose of the measure.
Shall Polk County authorize a five-year Fairgrounds/Event Center local option tax of up to $0.15/$1,000 assessed value beginning 2025-26?

This measure may cause property taxes to increase more than three percent.

Summary 175 words which concisely and impartially summarizes the measure and its major effect.

This measure authorizes Polk County to levy a five (5) year local option tax of up to $0.15/$1,000 assessed value beginning in 2025 for the purpose of providing funding to the Polk County Fairgrounds & Event Center for operations, maintenance and improvements.

Monies generated from the local option tax will be used for the operations and maintenance of the facility (approximately 25% annually), and the remaining monies will be utilized to make improvements to the electrical system, the resurfacing of the parking areas, replacing interior walkways and paths, interior/exterior improvements to the main building, HVAC upgrades for multiple buildings, the relocation of the maintenance shed, construction of a new main office where the maintenance shed was located, and the building of a new amphitheater/stage in the northwest corner of the property.

The authorization of this measure will impact a property with an Assessed Value of $300,000 (not Real Market Value) by increasing your current property taxes by $45.00 in year one of the measure.

The $0.15/$1,000 local option tax will generate $1,200,000 in 2025, $1,248,000 in 2026, $1,298,000 in 2027, $1,348,000 in 2028, and $1,400,000 in 2029 for a total of $6,494,000. The estimated tax cost for this measure is an ESTIMATE ONLY based on the best information available from the County Assessor at the time of estimate and may reflect the impact of early payment discounts, compression and the collection rate.

By signing this document:
→ I hereby state that I am authorized by the county or city governing body, or district elections authority to submit this Request for Ballot Title – Preparation or Publication of Notice.

Signature | **Date Signed**

BEFORE THE BOARD OF COMMISSIONERS
FOR THE COUNTY OF POLK, STATE OF OREGON

In the Matter of Modifying Chapter 15 to the Polk County Code of Ordinances)

ORDINANCE NO. 25-02

THE POLK COUNTY BOARD OF COMMISSIONERS ORDAIN AS FOLLOWS:

Sec. 1. Enactment. Polk County Code of Ordinances Chapter 15 is amended in the manner set forth in full as attached in Exhibit A.

Sec. 2. Severability. Should any section or portion of this ordinance be held unlawful or unenforceable by any court of competent jurisdiction, such decision shall apply only to the specific section, or portion thereof, directly specified in the decision. All other sections or portions of this ordinance shall remain in full force and effect.

Sec. 3. Emergency. This ordinance being immediately necessary to protect public safety and property, an emergency is declared, and this ordinance is effective immediately upon passage.

Dated: January 29, 2025 at Dallas, Oregon

POLK COUNTY BOARD OF COMMISSIONERS

_____
Craig Pope, Chairman

_____
Jeremy Gordon, Commissioner

_____
Lyle Mordhorst, Commissioner

Approved as to Form:

_____
County Counsel

First Reading: _____
Second Reading: _____
Recording Secretary: _____

CHAPTER 15

PUBLIC CONTRACTS AND PURCHASING

15.105 ADMINISTRATION

(1) Enabling Clause. Polk County Code of Ordinances Chapter 15 shall be binding upon all officers and employees of Polk County and shall govern all purchasing and contracting by officers and employees of Polk County. The Polk County Board of Commissioners may delegate all powers or duties given or assigned by this chapter to employees, officials or agents through a Board order.

(2) Local Contract Review Board. The Polk County Board of Commissioners shall act as the Local Contract Review Board pursuant to the authority granted to that Board by ORS Chapter 279A.060.

(3) Preference to Polk County Goods and Services. For purposes of awarding a public contract, a department shall give preference to goods or services that have been manufactured or produced in Polk County and immediate surrounding area if price, fitness, availability and quality are otherwise equal.

(4) Attorney General's Rules Inapplicable.

(a) The Attorney General's Model Contract Rules adopted under ORS 279A.065 do not apply to Polk County unless specifically referenced.

(b) Unless otherwise specified, this chapter shall also contain the procurement rules applicable to all County departments and divisions.

(5) Contract Signing Authority. Except as set out in this section, the Board of Commissioners, shall have the authority to enter into contracts on behalf of the department and the County.

(a) Notwithstanding the above, for contracts not to exceed $150,000.00, the County Administrative Officer and the Director of Public Works may enter into and sign contracts on behalf of the County.

(b) Notwithstanding the above, for contracts not to exceed $25,000.00 all elected heads of departments, and the directors of Administrative Services, Finance, Community Development, Behavioral Health, Community Corrections, Family and Community Outreach and Information Services may enter into and sign contract on behalf of the County.

(c) All contracts executed pursuant to subsection (a) and (b) must be provided to the appropriate person within the Commissioner's Office.

(6) All Contracts in Writing. All contracts to which Polk County is a party shall be in writing.

15.110 DEFINITIONS

As used in Polk County Code of Ordinances Chapter 15:

(1) "Bid" means a competitive offer, binding on the Bidder and submitted in response to an Invitation to Bid.

(2) "Board" means the Board of Commissioners of Polk County, acting as the local Contract Review Board.

(3) “Commissioners" means the Polk County Board of Commissioners.

(4) "Competitive Bid" means issuing an invitation to bid following the formal process for advertising, bid and bid opening.

(5) "Competitive Process" means the solicitation of competitive offers which follow the formal process for advertising, request for proposal, bid and bid opening, and applicable rules of the Board.

(6) "Competitive Quotes" means the solicitation of offers from competing vendors by advertisement or a request to vendors to make an offer. The solicitation and the offer may be in writing or oral. Oral quotes shall be reduced to writing in the procurement file.

(7) "County" means the Polk County Board of Commissioners or its public contracting officer(s).

(8) “Department” means a Polk County department such as, but not limited to, the Public Works Department or the Community Development Department.

(9) "Electronic Advertisement" means advertisement of an Offer available electronically over the internet via (i) the World Wide Web, or (ii) telnet, provided the County maintains an internet World Wide Web site that provides explicit instructions how an Entity can access the advertisement through the internet via a telnet application. The County may maintain the World Wide Web site directly or through any third party service provider.

(10) "Emergency" means that a substantial risk of loss, damage, interruption of services, or threat to the public health or safety has arisen from circumstances that could not have been reasonably foreseen.

(11) “Informal procurement” means any form of procurement outlined in this chapter that is not an invitation to bid or request for proposals.

(12) "Invitation to Bid" means the solicitation of competitive offers in which specification, price and delivery (or project completion) will be the predominant award criteria.

(13) ”Material and Service Contract” means an agreement in which the vendor agrees to supply all the purchaser's requirements that arise for an item or items within a specified time period. Also referred to as a Price Agreement.

(14) "Offer" means a bid, proposal, or quotation.

(15) "Offeror" means a person or firm submitting an offer.

(16) "Personal Property" means everything subject to ownership which is not real property, and which has exchangeable value.

(17) "Personal Services Contracts" means a contract that calls for specialized skills, knowledge and resources in the application of technical or scientific expertise, or the exercise of professional, artistic or management discretion or judgment. Qualifications and performance history, expertise, knowledge and creativity, and the ability to exercise sound professional judgment are typically the primary considerations when selecting a Personal Services Contractor, with price being secondary.

(18) "Proposal" means a competitive Offer, binding on the Proposer and submitted in response to a Request for Proposals.

(19) "Public Agency or Public Contracting Agency" means any agency of the federal government, State of Oregon or any political subdivision thereof authorized by law to enter into public contracts, municipality and any other public body created by intergovernmental agreement.

(20) “Public Contract” means any purchase, lease or sale by a public agency of personal property, public improvements or services other than agreements which are for personal services.

(21) "Public Contracting Officer” means the person or persons designated by the Commissioners to negotiate public contracts for the County.

~~(21)~~

(22) "Public Improvement" means a project for construction, reconstruction or major renovation on real property by or for a public agency. "Public Improvement" does not include emergency work, minor alterations, ordinary repair or maintenance necessary in order to preserve a public improvement.

(23) "Request for Proposal" means a solicitation of competitive proposals, or offers, to be used as a basis for making an acquisition, or entering into a contract when specification and price will not necessarily be the predominant award criteria.

(24) "Service Contract” means a contract that calls primarily for a contractor's time and effort rather than for an end product

(25) "Solicitation document" means an invitation for bids, a request for proposals, or a written request for quotations.

(26) "Telecommunications Systems" mean devices, components, facilities and applications that provide telecommunications services for the County and enable the aggregation and transmission of voice, video or data between and among County users. Telecommunications Systems may include gateway devices used to connect to private telecommunications networks or the Internet

15.115 PROCUREMENT METHODS

(1) Competitive Bids; Exemptions. All contracts shall be based upon competitive bids or proposals except the following:

(a) Contracts otherwise allowed or required in ORS 279A.025 (Application of Contracting Code) 279A.100 (Affirmative Action), , 279A.125 (Recycled Materials), 279A.128 (In-State Preference),

(b) Contracts that are for personal services. Such contracts may include incidental materials such as written reports or opinions, architectural or engineering renderings, and other supplemental materials required for providing the services.

(c) Contracts that may be procured by an alternative method based on ORS 279A.050; 279A.055 and 279A.070.

(d) The county may, in its discretion, let public contracts not to exceed $150,000 for the purchase of goods, materials, supplies, and services or for trade related projects, i.e., construction, maintenance, repair, or similar labor and materials contracts without competitive bidding, if the county has determined that the awarding of the contract without competitive bidding will result in cost savings and the contract is for a single project, and is not a component of or related to any other project.

(2) Exemptions for Contracts for Goods, Services, Construction and Maintenance Under Certain Dollar Amounts.

(a) When the amount of the contract does not exceed $2~~1~~5,000, the County may, but is not required to, obtain competitive quotes.

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(b) When the amount of the contract is more than $2~~1~~5,000, but less than $2~~1~~50,000, , the County shall ~~obtain~~ solicit a minimum of three competitive quotes. The County shall keep a written record of the source and amount of the quotes received. If three quotes are not available, a lesser number will suffice provided that a written record is made of the effort to obtain the quotes.

(c) When the contract is for a "public improvement" as defined in PCCC 15.110(23) or for "public works" as defined in ORS 279C.800, and the contract price exceeds $50,000, the County and the contractor shall comply with:

(i) The prevailing wage provisions of ORS 279C.800 to 279C.870, when applicable;

(ii) The performance bond requirements of PCCC 15.115(21) and ORS 279C.380;

(iii) The contractor registration requirements of ORS ch. 701; and

(iv) Any other law applicable to such a contract.

(3) Material and Service Contracts.

(a) Material and service contracts may be entered into without competitive bidding when it is in the best interests of the County to do so. The County may enter into material and service contracts whereby it is agreed to purchase goods or services for an anticipated need at a predetermined price provided the term of the contract, including renewals, does not exceed five years or $2~~1~~50,000.

(b) The County may also use the material and service contract entered into by another public contracting agency when a formal inter-agency agreement exists between the two agencies.

(4) Equipment Repair and Overhaul. Contracts for equipment repair or overhaul may be let without competitive bidding, if:

(a) Service and/or parts required are unknown and the cost cannot be determined without extensive preliminary dismantling or testing; or

(b) Service and/or parts required are for sophisticated equipment for which specially trained personnel are required and such personnel are available from only one source.

(5) Emergency Contracts.

(a) The county may, at its discretion, let public contracts without formal competitive bidding if an emergency exists and requires prompt execution of a contract to remedy or respond to the condition.

(b) The Commission may adopt a resolution indicating the existence of the emergency and stating with specificity the emergency conditions necessitating the prompt execution of the contract.

(c) Any contract awarded under this exemption shall be awarded within 60 days following declaration of the emergency unless an extension is granted by the Board, but such declaration shall not be required prior to entering into the contract depending on the circumstances of the emergency.

(d) The Commissioners may waive requirements for performance and payment bonds in the event of an emergency.

15.120 SOLICITATION PROCESS

(1) Solicitation Methods.

(a) Request for Proposal. The county may, at its discretion, use request for proposal competitive procurement methods subject to the following conditions:

(i) Contractual requirements shall be stated clearly in the solicitation document.

(ii) Evaluation criteria to be applied in awarding the contract and the role of an evaluation committee (if any) shall be stated clearly in the solicitation document. Criteria used to identify the proposal that best meets the county needs may include but are not limited to cost, quality, service, compatibility, product reliability, operating efficiency and expansion potential.

(iii) The solicitation document shall clearly state all complaint processes and remedies available.

(iv) The solicitation document shall state the provisions made for vendors to comment on any specifications which they feel limit competition.

(2) Invitation to Bid. The County may use an Invitation to Bid if the County believes it will receive optimal value by selecting the lowest priced offer that meets the technical requirements of the County's specifications.

(3) Negotiations.

(a) When All Bids Exceed Estimate. The County may negotiate with the lowest responsible bidder or proposer submitting a responsive bid if all responsive bids from responsible bidders or proposers exceed the County's cost estimate. If a written cost estimate was not prepared prior to bidding, the amount budgeted for the public contract shall be deemed the cost estimate for the purposes of this subsection.

(b) Other Bids. The County may negotiate with a proposer to clarify its quote, bid or proposal or to effect modifications that will make the quote, bid or proposal acceptable or more advantageous to the County.

(4) Prequalification.

(a) The County, in its sole discretion, may require bidders or proposers to prequalify before being eligible to submit bids or proposals for a class of public contracts or for a particular public contract. The method used to prequalify bidders or proposers shall be determined by the Department letting the contract.

(b) The County shall, in response to the receipt of a prequalification application submitted under this section, notify the prospective bidder or proposer whether the prospective bidder or proposer is qualified based on the standards identified by the County and ORS 279B.110(2), the type and nature of contracts that the prospective bidder or proposer is qualified to compete for and the time period for which the prequalification is valid. If the County does not prequalify a prospective bidder or proposer as to any contracts covered by the prequalification process, the notice must specify which of the County's criteria and/or standards of responsibility listed in ORS 279B.110(2) the prospective bidder or proposer failed to meet. Unless the reasons are specified, the prospective bidder or proposer shall be deemed to have been prequalified in accordance with the application.

(c) Disqualification. Disqualification of a previously prequalified bidder or proposer shall be in accordance with this chapter and the provisions of ORS 279B.120(3) regarding prequalification and disqualification.

(5) Product Prequalification.

(a) When it is impractical to create or reproduce specific design or performance specifications for a type of product to be purchased, the county may specify a list of approved or qualified products by reference to a particular manufacturer or seller in accordance with the following product prequalification procedure:

(i) The County shall make reasonable efforts to notify all known manufacturers and vendors of competitive products of its intention to accept applications for inclusion in its list of prequalified products. Notification shall include advertisement in a trade journal of state-wide distribution when possible. In lieu of advertising, the County may notify vendors and manufacturers appearing on the appropriate list maintained by the State of Oregon.

(ii) The County shall permit application for prequalification of similar products up to 15 days prior to advertisement for bids on the product.

(b) If an application for inclusion in a list of prequalified products is denied, or an existing prequalification revoked, the County shall notify the applicant in writing. The applicant may appeal to the local Contract Review Board.

(6) Life Cycle Costing. In determining the lowest responsible bidder in the award of a contract, the county may use the concept of life cycle costing. As used in this section, life cycle costing means determining the cost of a product for its useful life.

(a) Prior to the time of writing specifications for the product, the public contracting agency shall identify those factors which will have cost implications over the life of the product.

(b) The Invitation to Bid shall set out clearly the factors and methodology to be used in life cycle cost adjustments.

(c) At or after the bid opening, the results of life cycle costing adjustments shall be applied to the base bid, and the bidder whose total bid results in the lowest ownership cost, taking into account the life cycle costing adjustments, shall be considered the lowest responsible bidder.

(7) Advertisement. Advertisements of invitations for bids and requests for proposals shall be published as set forth herein, and any other time the County concludes that advertisement is desirable.

(a) An advertisement, other than for a public improvement contract estimated to cost more than $2~~1~~50,000, shall be deemed sufficient for the purposes of this chapter if it appears once in the Itemizer Observer or the Statesman Journal, or, if the Local Contract Review Board has authorized electronic advertisement and~~,~~ it appears electronically in a commercially reasonable manner. Nothing in this section shall be deemed to prevent a department from satisfying the advertisement requirements of applicable statutes and this ordinance by publishing an advertisement once in any newspaper of general circulation in the Polk County metropolitan area.

(b) An advertisement for a public improvement contract estimated to cost more than $2~~1~~50,000 shall be deemed sufficient if it appears once in the Daily Journal of Commerce or a similar trade newspaper of general statewide circulation and once in the Itemizer Observer or

Statesman Journal.

(c) A department may publish an advertisement more than once, and in addition to publication designed to satisfy the requirements of applicable statutes and this ordinance, may publish one or more advertisements in any local, regional, or national publication deemed by the department to be appropriate for the particular procurement.

~~(d) A department shall give public notice at least seven (7) days before the solicitation closing date.~~

(8) Contents of Advertisements. All advertisements for offers or proposals shall state:

(a) The date after which bids will not be received, which shall not be less than seven (7) days after the date of the last publication of the advertisement;

(b) The date that prequalification applications must be filed if applicable and the class or classes of work for which bidders must be prequalified if prequalification is a requirement;

(c) A general description of the work to be done or the material or things to be purchased;

(d) The office where the specifications for the work, material or things may be reviewed;

(e) The name, title and address of the person designated to receive offers or proposals;

(f) The date, time and place that the County will open the bids;

(g) If the contract is for a public work subject to ORS 279C.800 to 279C.870 or the Davis- Bacon Act (40 U. S. C. 276a).

(9) Requirements for Bid or Proposal Documents and Bids; Disclosure of First-tier Subcontractors.

(a) Bid or proposal documents for a public contract shall, at a minimum, include:

(i) A general description of the work to be done or the material or things to be purchased and performance expectations, including a statement that the contractor shall meet the highest applicable industry or business standards in providing the goods or services;

(ii) The office where the specifications for the work, material or things may be reviewed;

(iii) The date, time and place that prequalification applications must be filed if applicable and the class or classes of work for which bidders or proposers must be prequalified if prequalification is a requirement;

(iv) The date and time after which bids or proposals will not be received, which shall be at least seven (7) days after the date of the last publication of the advertisement;

(v) The place, name and title of the person designated for receipt of bids or proposals;

(vi) The date, time and place that the County will open the bids;

(vii) A statement that each bid or proposal must identify whether the bidder is a resident bidder, as defined in ORS 279A.120.

(viii) A description of the selection criteria to be utilized in evaluating bids or proposals and determining the successful bid or proposal.

(ix) A statement that the County may reject any bid not in compliance with all prescribed bidding procedures and requirements, and may reject for good cause any or all bids or proposals upon a finding of the County that it is in the public interest to do so;

(x) All contractual terms and conditions applicable to the bid or proposal and consequences for failure to perform the work to industry or business standards;

(b) All bids or proposals made to the County shall be:

(i) In writing;

(ii) Filed with the person designated for receipt of bids; and

(iii) Bids, but not proposals, opened at the time designated in the advertisement.

(c) In addition to the requirements of subsections (a) and (b) of this section, bid or proposal documents for public improvement contracts shall also include:

(i) A statement that, if the contract is for a public work subject to ORS 279C.800 to 279C.870 or the Davis-Bacon Act (40 U.S.C. 276a), no bid will be received or considered unless the bid or proposal contains a statement that the provisions of ORS 279C.838 or 279C.840 or 40 U.S.C. 276a are to be complied with;

(ii) Information addressing whether a contractor or subcontractor must be licensed under ORS 468A.720;

(iii) A statement that no bid or proposal for a public improvement contract shall be received or considered unless the bidder or proposers are licensed by the Construction Contractors Board or the State Landscape Contractors Board;

(iv) A statement that every public improvement contract shall contain a condition that the contractor shall:

(A) Make payment promptly, as due, to all persons supplying to such contractor labor or material for the performance of the work provided for in such contract.

(B) Pay all contributions or amounts due the Industrial Accident Fund from such contractor or subcontractor incurred in the performance of the contract.

(C) Not permit any lien or claim to be filed or prosecuted against the state, county, school district, municipality, municipal corporation or subdivision thereof, on account of any labor or material furnished.

(D) Pay to the Department of Revenue all sums withheld from employees pursuant to ORS 316.167.

(v) In addition to the conditions specified in subsection (a) of this section, every public improvement contract shall contain a condition that the contractor shall demonstrate that an employee drug testing program is in place.

(vi) Within two working hours after the date and time of the deadline when the bids or proposals are due for a public improvement, a bidder shall submit to the County a disclosure of any first-tier subcontractor that:

(A) Will be furnishing labor or labor and materials in connection with the public improvement; and

(B) Whose contract value is equal to or greater than five percent of the total project bid or $15,000, whichever is larger, or $350,000, regardless of the percentage of the total project bid.

(vii) The disclosure of first-tier subcontractors shall include:

(A) The name of each subcontractor;

(B) The category of work each subcontractor will perform; and

(C) The dollar value of each subcontract.

(viii) For each contract to which subsections (c) (vi) and (vii) applies, the County shall designate a deadline for submission of bids or proposals that has a date on a Tuesday, Wednesday or Thursday and a time between 122 p.m. and 35 p.m., except that this subsection does not apply to public contracts for maintenance or construction of highways, bridges or other transportation facilities.

(ix) Subsections (c) (vi) and (vii) shall apply only to public improvements with an estimated contract value of more than $100,000.

(10) Offer Preparation.

(a) Instructions. An offeror or proposer shall submit and sign its offer or proposal in accordance with the solicitation document. An offeror or proposer shall initial any alteration or erasure to an offer or proposal, if any, in accordance with the solicitation document.

(b) Documents. An offeror or proposer shall provide the County with all documents and descriptive literature required under the solicitation document.

(11) Method of Submitting Offers.

(a) Receipt. Bids must be submitted in writing. The County shall not open the offeror modification, but shall date and time stamp the offer and store it in a secure place until opening. If the County inadvertently opens an offer, proposal or a modification, prior to the opening, the County shall reseal and store the opened offer, proposal or modification for opening. The County shall document the resealing for the solicitation file (e.g. County inadvertently opened the offer or proposal due to improper identification of the offer).

(b) Timeliness. Offerors or proposers are responsible for ensuring their offers or proposals are timely. The County may decline to consider a late offer, even if the offer or proposal is late because of a delay in the County's internal handling of mail or documents or because the County's receiving equipment was unavailable.

(c) Completeness. Offerors or proposers are responsible for ensuring their offers or proposals are received by the County in a complete, legible, ungarbled form. The County may decline to consider an offer that is incomplete, illegible, or garbled, even if the problem is caused by the County's hardware or software.

(d) Facsimile or electronic mail Submissions. Notwithstanding subsection (a), an offeror or proposer may submit its offer or proposal by facsimile or electronic mail only if expressly allowed under the solicitation document. The County shall not consider facsimile or electronic mail offers or proposals unless authorized by the solicitation document

(12) Bid and Proposal Opening.

(a) Bids shall be opened by the contracting officer as described in the solicitation documents.

(b) The County may open proposals at any time. There is no requirement for proposals to be opened in public.

(c) Subject to any exemptions under Oregon public records statutes, bids and proposals shall be available for public inspection only after the County has finished evaluating them.

(13) Retainage on Public Contracts. Retainage, if any, shall be determined on a case by case basis by the public contracting officer, shall be specified by contract between the parties and shall conform to the requirements of ORS 279C.550 through 279C.570.

(14) Bid Evaluation

(a) Generally. Opened bids shall be evaluated in accordance with the evaluation criteria outlined in the bid documents applicable statutes and this Chapter. When a bid is determined to be unresponsive to the invitation for bids, it will not be evaluated further.

(b) Correction of Certain Errors. Arithmetic errors apparent on the face of a bid shall be corrected by the County before comparing bid prices. Discrepancies between a unit price and an extended total price for a bid item shall be resolved in favor of the unit price unless there is evidence apparent on the face of the bid establishing that the extended price is correct.

(15) Proposal Evaluation. Proposals shall be evaluated based upon the evaluation criteria established by the request for proposals. Changes in evaluation criteria shall be communicated to all proposers or prospective proposers by addendum. If evaluation criteria are changed after proposals have been submitted, all proposers shall have an opportunity to supplement their proposals or submit best and final offers after receipt of the addendum changing the evaluation criteria.

(16) Rejection of Bid or Proposal.

(a) The County may reject a bid or proposal if it finds:

(i) The person has not substantially complied with all prescribed bidding procedures and requirements.

(ii) If it is in the public interest to reject some or all of the bids or proposals.

(iii) The person has not met the standards of responsibility. In making a written determination whether a prospective bidder or proposer has met the standards of responsibility, the County shall consider whether a prospective bidder or proposer has:

(A) Available the appropriate financial, material, equipment, facility and personnel resources and expertise, or ability to obtain the resources and expertise, necessary to indicate the capability of the prospective bidder or proposer to meet all contractual responsibilities;

(B) Current, necessary licenses;

(C) Liability and other insurance in amounts necessary to meet bid or proposal requirements;

(D) Workers compensation coverage pursuant to ORS 656.407 or 656.128;

(E) Made the first-tier subcontractor disclosure required by ORS 279C.370;

(F) A satisfactory record of performance. The County shall document the record of performance of a prospective bidder or proposer if the County finds the

prospective bidder or proposer not to be responsible under this sub-subparagraph;

(G) A satisfactory record of integrity. The County shall document the record of integrity of a prospective bidder or proposer if the County finds the prospective bidder or proposer not to be responsible under this sub-subparagraph;

(H) Qualified legally to contract with the County;

(I) Supplied all necessary information in connection with the inquiry concerning responsibility. If a prospective bidder or proposer fails to promptly supply information requested by the County concerning responsibility, the County shall base the determination of responsibility upon any available information, or may find the prospective bidder or proposer not to be responsible; and

(J) Not been debarred by the County under ORS 279B.130.

(b) The County may make such investigation as is necessary to determine whether a person is qualified. If a bidder or prospective bidder fails to supply promptly information as requested by the public contracting officer pursuant to such investigation, such failure is grounds for disqualification.

(17) Irrevocability of Offers

(a) Bids. All bids received by the County for a particular public contract become binding offers when the first bid is opened, and remain irrevocable for ~~30~~ 45 calendar days after opening unless a different period is specified in the invitation for bids.

(b) Proposals. All proposals received by the County for a particular contract shall become binding offers on the last date for the receipt of best and final offers or, if best and final offers are not invited or permitted, at the beginning of the County's final evaluation of proposals, and shall remain irrevocable for 60 calendar days thereafter unless a different period is specified in the request for proposals.

(c) Extensions by County. The County may request, orally or in writing, that offerors extend, in writing, the time during which the County may accept their offer(s). If an offeror agrees to such extension, the offer shall be irrevocable, valid and binding on the offeror for the agreed upon extension.

(18) Cancellation. The County may cancel a procurement at any time before a contract is signed, if the County determines cancellation is in the County's best interests. If a procurement is canceled, the County shall not be liable for any costs incurred by prospective offerors. If a procurement is canceled before bids or proposals are opened, the bids or proposals shall be returned to the bidders and proposers unopened, except that the County may open a bid or proposal to determine the identity and address of the bidder or proposer if the name and address are not shown on the outside of the envelope. If a procurement is canceled after bids or proposals are opened, the County shall retain the bids or proposals. The reason[s] for the cancellation shall be made part of the solicitation file.

(19) Contract Amendments. Any contract amendment, including change orders, extra work, field orders, or other change in the original specifications which increases the original contract price or alters the work to be performed, may be made with the contractor subject to the following conditions:

(a) The original contract, regardless of price, was awarded pursuant to these rules or ORS chapter 279A, 279B or 279C, unit prices or bid alternatives were provided that established the cost for additional work, and a binding obligation exists on the parties covering the terms and conditions of the additional work; or

(b) The amount of the aggregate cost increase resulting from all amendments does not exceed 20% of the initial contract, or 25% of the initial contract when the initial contract is for a face amount not exceeding $2~~1~~50,000. Amendments made pursuant to subsection (1) of this section are not included in computing the aggregate amount under this section.

(20) Notice of Intent to Award. At least seven (7) days before the award of a public contract by bid or proposal, unless the department determines seven days is impractical, the department shall post or provide to each bidder or proposer notice of the department's intent to award a contract. This section does not apply to a contract awarded for less than $2~~1~~50,000, an emergency procurement, a sole source procurement or a contract awarded under any exemption or alternative contracting method listed in this chapter.

(21) Performance Security Requirements.

(a) Public Improvements Contracts. Unless the contract review board waives the required performance bond, or in the event of an emergency, or unless the local contract review board exempts a contract or classes of contracts from the required performance bond pursuant to these rules, the contractor shall execute and deliver to the County a performance bond and a payment bond each in a sum equal to the contract price for all public improvement contracts in excess of $100,000, or in the case of contracts for highways, bridges or other transportation projects in excess of $50,000.

(b) Public Improvement Contracts Under $100,000. The County may require a performance bond and/or a payment bond for public improvement contracts under $100,000, but the County shall not use such requirement to discourage competition.

(c) Other Public Contracts. The County may require performance security for other public contracts. Such requirements shall be expressly set forth in the solicitation document.

(d) Form of Security. The County may accept only the following forms of Bid or Proposal security:

(i) A surety bond from a surety company authorized to do business in the State of Oregon;

(ii) An irrevocable letter of credit issued by an insured institution as defined in ORS 706.008; or

(iii) A cashier's check or certified check.

(e) Time for Submission. Upon the County's request, the apparent successful offeror must furnish the required performance bond and/or payment bond within 10 days. If the offeror fails to furnish the bond within the 10 day period, the County may reject the offer and award the contract to the next lowest responsive, responsible bidder or next highest-scoring responsive, responsible proposer, and, at the County's discretion, the offeror shall forfeit its bid or proposal security.

15.125 PERSONAL SERVICES CONTRACTS

(1) Generally

(a) Personal service contracts are not public contracts subject to competitive bidding provisions of ORS Chapters 279A, 279B, 279C or this Chapter.

(b) A department may enter into a personal service contract with an independent contractor without competitive bidding when the department needs to have a personal service performed as provided in this section. Each department may establish screening and selection processes.

(2) Cost Analysis.

(a) No personal service contract exceeding $250,000 in total value shall be entered without competitive procurement unless a cost-benefit analysis is first performed to determine whether it is more cost efficient to perform the service in-house.

(b) A personal service shall not be procured unless the department can demonstrate, in writing, by means of a cost analysis that:

(i) The overall cost to procure the service(s) is less than the cost to perform the service(s) in-house; or

(ii) Performing the service(s) with existing county personnel or resources is not feasible.

(c) The cost benefit analysis shall be conducted pursuant to ORS 279B.030.

(d) A cost benefit analysis is not required for the following categories of services or contracts:

(i) Public improvement contracts;

(ii) Client services, including mental health and human services described in OAR 125-246-0110; or

(iii) Situations in which the county does not have the staff available or the necessary expertise to perform the service(s).

(3) Personal Services.

(a) The nature of the tasks to be performed, the needs of the department and the interests of the public form the basis for distinguishing between personal service contracts and public contracts. Hence, if the department requires goods or services for which the department has developed or is reasonably able to develop, respectively, adequate design and/or performance specifications; and selecting a contractor on the basis of lowest price would be likely to meet the department's needs, then the tasks should be performed pursuant to a public contract let in accordance with the competitive bidding provisions of this Chapter.

(b) Conversely, if a department is reasonably unable to develop adequate design and/or performance specifications but must instead have the assistance of the contractor's training, knowledge and expertise to develop a scope of work statement and selecting the contractor on the basis of lowest price would be unlikely to meet the department's needs, then the tasks would most appropriately be performed under a personal service contract. In determining whether its needs will be met through award of a personal service contract rather than a public contract, the department should consider whether selecting the contractor on the basis of qualifications rather than lowest price will result in the department obtaining the best value for its money.

(c) A personal service contract is not appropriate where price is or should be the primary selection criterion. A public contract, in contrast to a personal service contract, will be awarded primarily on the basis of price; criteria such a technical skill, creativity, artistic ability, performance history, and demonstrated ability to be taken into account during the selection process, will be of only secondary importance. Unless otherwise statutorily excepted, a public contract must be awarded based on either competitive bidding, or an alternative competitive process under this Chapter.

(4) Examples of Personal Service Contracts. Personal service contracts may include, but are not limited to the following:

(a) Contracts for services performed as an independent contractor in a professional capacity, including but not limited to the services of an accountant, attorney, architectural or land use planning consultant, physician or dentist, registered professional engineer, appraiser or surveyor, passenger aircraft pilot, aerial photographer, timber cruiser, information technology consultant or broadcaster;

(b) Contracts for services as an artist in the performing or fine arts, including but not limited to persons identified as photographer, film maker, painter, weaver, or sculptor;

(c) Contracts for services of a specialized creative and research-oriented, noncommercial nature;

(d) Contracts for services as a consultant;

(e) Contracts for educational and human custodial care services.

(5) Examples of Contracts Not for Personal Services. The following are not personal service contracts:

(a) Contracts, even though in a professional capacity, if predominately for a product e.g., a contract with a landscape architect to design a garden is for personal services, but a contract to design a garden and supply all the shrubs and trees is predominately for a tangible product;

(b) A service contract, including a contract with a temporary service or personnel agency, to supply labor which is of a type that can generally be done by any competent worker, e.g., data entry, key punch, janitorial, security guard, crowd management, crop spraying, laundry, and landscape maintenance service contracts;

(c) Contracts for trade-related activities considered to be labor and material contracts;

(d) Contracts for services of a trade-related activity, to accomplish routine, continuing and necessary functions, even though a specific license is required to engage in the activity. Examples are repair and/or maintenance of all types of equipment or structures.

15.130 CONTRACTS EXEMPT FROM COMPETITIVE BIDDING

(1) Purchases Under Federal Contracts or from Federal Agencies.

(a) When the price of goods and services has been established by a contract with an agency of the federal government pursuant to a federal contract award, the County may purchase the goods and services in accordance with the federal contract without subsequent competitive bidding. In exercising this authority under this exemption, the County shall:

(i) Include in the contract file a letter or memoranda from the appropriate federal agency granting permission to purchase under the federal contract; and

(ii) Include in the contract file documentation showing the cost savings to be gained from anticipated purchases from the federal contract.

(b) Departments may also purchase equipment and supplies from federal government catalogues maintained by the United States Administrator of General Services without competitive bidding.

(c) Departments may purchase goods and equipment from the federal government under 10 U.S.C. 381, the Electronic Government Act of 2002 or other federal law that is similar, or section 211 of that Act.

(d) The County shall not contract pursuant to this provision if there is an existing state price agreement for the same item(s).

(2) Food Contracts. Procurement of food or food products which are available at "lower than normal" prices.

(3) Purchases of Used Personal Property. The County may purchase used personal property for $2~~1~~00,000 or less without competitive bidding if the department has determined that the direct purchase without competitive bidding will result in cost savings and if no violation of ORS 244.040 will result from the purchase. For purchases of used personal property over $2~~1~~00,000, three competitive quotes shall be obtained. If three quotes are not available, a written record must be made of the attempt to obtain quotes.

(4) Gasoline, Diesel Fuel, Heating Oil, Lubricants and Asphalts. The County is exempt from formal competitive bidding requirements for the purchase of gasoline, diesel fuel, heating oil, lubricants and asphalts if the county seeks competitive quotes from the majority of vendors in the area, makes its purchase from the least expensive source, and retains written justification for the purchase made.

(5) Cooperative Procurements. A department that chooses to participate in, sponsor, conduct or administer a Joint Cooperative Procurement, Permissive Cooperative Procurement or Interstate Cooperative Procurement may do so only in accordance with ORS 279A.210, 279A.215 or 279A.220. If a department utilizes this exemption and the estimated value of the contract exceeds $250,000, the department shall follow the process set forth in ORS 279A.215(2) and (3).

(6) Hazardous Material Removal; Oil Cleanup.

(a) The County may enter into public contracts without competitive bidding, regardless of dollar amount, when ordered to clean up oil or hazardous waste pursuant to the authority granted the State Department of Environmental Quality (DEQ), under ORS chapter 466, and in particular, ORS 466.605 through 466.680. In exercising its authority under this exemption the County shall:

(i) To the extent reasonable under the circumstances, encourage competition by attempting to make informal solicitations or to obtain informal quotes from potential suppliers of goods or services;

(ii) Make written findings describing the circumstances requiring cleanup or a copy of the DEQ order ordering such cleanup; and

(iii) Record the measures taken under subsection (a) to encourage competition, the amount of the quotes or proposals obtained, if any, and the reason for selecting the contractor selected.

(b) The County shall not contract pursuant to this exemption in the absence of an order from DEQ to clean up a site with a time limitation that would not permit hiring a contractor under the usual competitive bidding procedures.

(7) Other Exempt Contracts. The County may, regardless of dollar value and without competitive bidding, enter into contracts for the direct purchase of the following goods or services:

(a) Advertising and Promotional Contracts.

(b) Ballots, Ballot Pages, and Ballot Cards. The County may enter into contracts for the printing of ballots, including ballot pages and labeling of ballot cards.

(c) Copyrighted Materials. The County may purchase copyrighted materials if there is only one known supplier available for such goods. Examples of copyrighted materials covered by this exemption may include, but are not limited to, new adopted textbooks, workbooks, curriculum kits, reference materials, books, periodicals, audio and visual media, and non-mass- marketed software.

(d) Employee Benefit Insurance. The County may purchase insurance products including property, liability, workers compensation and employee benefit insurance or plans.

(e) Equipment Maintenance. Contracts for the purchase of services, equipment, or supplies for the maintenance, repair or conversion of existing equipment are exempt if required for the efficient utilization of the equipment. Where practicable, competitive quotes shall be obtained.

(f) Investment Contracts. The County may contract for the purpose of the investment of public funds or the borrowing of funds pursuant to a resolution, statute, ordinance, or charter.

(g) Laboratory and Medical Supplies. The County may contract for the following:

(i) Drugs, including 340B pharmacy drugs (government regulated drugs), biologicals, blood fractions, and blood components;

(ii) Intravenous solutions and associated supplies for administration;

(iii) Microbiologicals, biochemicals, and diagnostic reagents;

(iv) Surgical dressings;

(v) Heart valves;

(vi) E.E.G., E.K.G, electrodes, charts, and associated supplies;

(vii) Sterilizing wraps;

(viii) Catheters, medical tubes, and associated supplies;

(ix) Surgical and orthopedic instruments;

(x) Hearing aids;

(xi) Pacemakers;

(xii) Dental supplies;

(xiii) Laboratory small package chemicals;

(xiv) Biology supplies; and

(xv) Therapeutic or cosmetic implants.

(h) Medical Purchasing Cooperatives. A department which is a member of a legally established purchasing cooperative may purchase hospital and medical supplies and equipment, as well as

lab testing services and pharmacy services through the cooperative.

(i) Office Supplies. Consumable office supplies including, but not limited to copy paper, pens, copier toner, binders, etc.

(j) Pass-Through Grants. A grant under which the county passes through to another recipient all or a portion of the money or property received by the county from a federal or state agency, provided that:

(i) The county does not add or modify the original grant except as necessary to provide proper administration; and

(ii) The grant contains a clause substantially in the following form: "The recipient of grant funds, pursuant to this agreement with the County, shall assume sole liability for recipient's breach of the conditions of the grant, and shall upon recipient's breach of grant conditions that causes or requires the County to return funds to the grantor, hold harmless and indemnify the County for an amount equal to the funds which the County is required to pay to the grantor.

(k) Periodicals. The County may purchase subscriptions for periodicals, including journals, magazines, and similar publications without competitive bidding.

(l) Price Regulated Items. The County may contract for the direct purchase of goods or services where the rate or price for the goods or services being purchased is established by federal, state or local regulatory authority.

(m) The County may engage in cooperative procurements as set forth in ORS 279A.200-225.

(8) Specific Exemptions

(a) Exemptions Requests. The Contract Review Board may exempt a particular contract or contracts from the bidding requirements of this chapter or ORS 279C.335 which are not otherwise exempted under these sections upon approval of the following findings:

(i) The nature of the project;

(ii) Estimated cost of the project;

(iii) A narrative description of the cost savings anticipated by the exemption from competitive bidding and the reasons competitive bidding would be inappropriate;

(iv) Proposed alternative contracting and purchasing practices to be employed;

(v) The estimated date by which it would be necessary to let the contract;

(vi) It is unlikely that such exemption will encourage favoritism in the awarding of public contracts or substantially diminish competition for public contracts; and

(vii) The awarding of public contracts pursuant to the exemption will result in substantial cost savings to the County. In making such finding, the board may consider the type, cost and amount of the contract, number of persons available to bid and such other factors as may be deemed appropriate.

(viii) Otherwise substantially promotes the public interest in a manner that could not practically be realized by complying with this chapter.

(ix) The Board may require such additional information as is deemed necessary to determine whether a specific contract is to be exempt from competitive bidding.

(b) Approval of Requests. Before final adoption of the findings required by this section exempting a contract for a public improvement from the requirement of competitive bidding, the County shall hold a public hearing pursuant to ORS 279C.335(5).

15.135 DISPOSITION OF SURPLUS PERSONAL PROPERTY

(1) Sales of Surplus Personal Property.

(a) Prior to sale pursuant to this chapter, personal property must be declared surplus. County department heads may declare property with an estimated value below $5~~3~~,000.00 surplus. Property with an estimated value above $5~~3~~,000.00 must be declared surplus by the Board of Commissioners.

(b) Surplus Personal property may be sold at auction if the County determines that the auction contemplated may result in a higher net return than if the property were sold by competitive written bid.

(c) The County may sell surplus personal property, including recyclable or reclaimed materials, without formal competitive bidding if it has determined that a negotiated sale will result in increased net revenue or the current market value per item is deemed to be less than $15,000. The County may establish a selling price, schedule and advertise a sale date, and sell to the first qualified buyer meeting the sale terms.

(d) When the current value per item is deemed to exceed $15,000, the surplus personal property must be offered for competitive bid and be advertised, or be offered for sale at public auction in accordance with this Chapter. If no bids are received or if a determination is made that the market value of the property exceeds the offer of the highest responsible bidder, all bids may be rejected and the county may negotiate a sale subject to the following conditions:

(i) An appraisal of the market value of the property is obtained and documented and the negotiated sale price exceeds the market value; or

(ii) The sale amount exceeds the highest bid received through the bidding or auction process.

(e) The County may sell surplus personal property through a commercially recognized third party liquidator if it has determined that a liquidation sale will result in increased net revenue.

(2) Donations of Personal Property.

(a) The County may donate or sell surplus personal property of any value, without competitive bidding, including recyclable or reclaimed materials to another public agency, or any sheltered workshop, or nonprofit organization, after a determination has been made that the personal property is not needed for other county purposes.

(b) The County shall maintain a record of all transfers or donations sales authorized by this section.

(3) For the purposes of this section, the trade in or exchange of surplus County personal property to an equipment dealer in conjunction with a purchase from that dealer will not be considered a disposition of personal property nor subject to any requirements in this section.

15.140 CONTRACTS REQUIRING MODIFIED PROCUREMENT PROCEDURES

(1) Information and Telecommunication Systems Contracts.

(a) Contracts for acquisition of information technology and/or telecommunication system hardware and software may be let using alternate competitive procurement methods subject to the following conditions:

(i) If the contract amount does not exceed $2~~1~~50,000, the County contracting agency shall, as a minimum, follow informal competitive procurement methods. Prior to selection of a vendor, reasonable efforts will be made to solicit proposals from three or more vendors. Justification of award shall be documented and become a public record of the county.

~~(i)~~

(ii) If the contract amount exceeds $2~~1~~50,000, the County may use the request for proposal process and shall solicit written proposals pursuant to this chapter. The County shall document the evaluation and award process, which will be part of the public record justifying the award.

~~(iii)~~(ii) ~~If the amount of the contract is estimated to exceed $500,000, in addition to the requirements of subsections (1)(b) of this section, the County shall provide proposers the opportunity to review the evaluation of their proposal before final management review and selection~~.

(b) Telecommunications solicitation authorized in subsection (1) shall:

(i) State the contractual requirements in the solicitation document;

(ii) State the evaluation criteria to be applied in awarding the contract and the roles of any evaluation committee. Criteria that would be used to identify the proposal that best meets the County's needs may include, but are not limited to, cost, quality, service and support, compatibility and interconnectivity, product or system reliability, vendor viability and financial stability, operating efficiency, and expansion potential;

(iii) State the provisions made for vendors to comment on any specifications which they feel limit competition.

(2) Telecommunications Services and Equipment.

(a) In determining the appropriate procurement method for telecommunications services, the department will determine whether competition exists. In determining competition, the department may consider the following factors:

(i) The extent to which alternative providers exist in the relevant geographic and service market. The relevant market will vary from service category to service category and cannot be pre-determined in advance. For example, an alternative long distance provider might offer services in Portland, but not in Medford, or the rest of the state.

(ii) The extent to which alternative services offered are comparable or substitutable in technology, service provided, and performance. For example, if the department requirement is for digital services, analog services are not comparable or substitutable.

(iii) The extent to which alternative providers can respond to the department's interests in consistency and continuity of services throughout its service area, volume discounts, equitable service for all users, centralized management, and limiting the County's liability.

(b) Upon determination that competition does not exist for the relevant service and geological

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area, the department may proceed to secure the service on a sole source basis.

(3) Office Copier Purchases.

(a) The County may enter into multiple price agreements or material and service contracts for the purchase, rental or lease of office copying equipment. Except for this multiple award exemption, such agreements shall otherwise conform to the requirements of PCCO 15.115.

(b) In exercising this exemption the County shall fully consider the operating capabilities, limitations and cost of each brand or model and select the brand which will produce the best combination of performance and cost per copy for each application.

(4) Specification of Particular Brand Names or Product.

(a) A brand name or equal specification may be used when the use of a brand name or equal specification is advantageous to the department, because the brand name describes the standard of quality, performance, functionality and other characteristics of the product needed by the department.

(b) The department is entitled to determine what constitutes a product that is equal or superior to the product specified, and any such determination is final.

(c) Nothing in this section may be construed as prohibiting a department from specifying one or more comparable products as examples of the quality, performance, functionality or other characteristics of the product needed by the department.

(d) A brand name specification may be prepared and used only if the department determines for a solicitation or a class of solicitations, including for public improvements, that only the identified brand name specification will meet the needs of the department based on one or more of the following written findings:

(i) It is unlikely that such exemption will encourage favoritism in the awarding of public contracts or substantially diminish competition for public contracts;

(ii) The specification of a product by brand name or mark, or the product of a particular manufacturer or seller, would result in substantial cost savings to the department;

(iii) There is only one manufacturer or seller of the product of the quality, performance or functionality required; or

(iv) Efficient utilization of existing goods requires the acquisition of compatible goods or services.

(5) Purchasing From Sole Source, Single Seller.

(a) A department may purchase a particular product or service available from only one source, after documenting the procurement file with findings of current market research to support the determination that the product is available from only one seller or source. The department's findings shall also include:

(i) A brief description of the contract or contracts to be covered including contemplated future purchases;

(ii) Description of the product or service to be purchased; and

(iii) The reasons the department is seeking this procurement method, which shall include

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any of the following:

(A) Efficient utilization of existing goods requires the acquisition of compatible goods or services; or

(B) That the goods or services required for the exchange of software or data with other public or private entities are available from only one source; or

(C) The particular goods or services are for use in a pilot or an experimental project.

(D) Other findings that support the conclusion that the goods or services are available from only one source.

(b) If the department intends to make several purchases of the product or service from a sole source for a period not to exceed five years, it may so state in the solicitation file and in the solicitation document, if any. Such documentation shall be sufficient notice as to subsequent purchases.

(6) Single Manufacturer, Multiple Sellers.

(a) The County may specify a product or service available from only one manufacturer but available through multiple sellers, after documenting the procurement file with the County's information required in this subsection, and subject to the following:

(i) If the total purchase is $2~~1~~5,000 or more but does not exceed $2~~1~~50,000 and a comparable product or service is not available under an existing state requirements contract, competitive quotes shall be obtained and retained in the procurement file; or

(ii) If the amount of the purchase exceeds $2~~1~~50,000, the product or service shall be obtained through competitive bidding.

(b) If the County intends to make several purchases of the product of a particular manufacturer or seller for a period not to exceed five years, it may so state in the solicitation file and in the solicitation document, if any. Such documentation shall be sufficient notice as to subsequent purchases. If the total purchase amount is estimated to exceed $2~~1~~50,000, this shall be stated in the advertisement for bids or proposals.

15.145 APPEALS

(1) Procedure. The procedure for appeals from decisions of the public contracting officer shall be as follows:

(a) Notices of appeal shall be in writing addressed to the public contracting officer and must be submitted no later than 14 calendar days from the date of the challenged decision.

(b) Immediately upon receipt of written notice of appeal, the public contracting officer shall inform the Board.

(c) Upon receipt of notice of appeal, the Board shall notify the person appealing of the time and place of the hearing.

(d) The Board shall conduct a de novo hearing according to the provisions of ORS 279.045(3) and decide the appeal within 30 days after receiving the notification and shall set forth in writing the reasons for its decisions.

BEFORE THE BOARD OF COMMISSIONERS FOR
POLK COUNTY, OREGON

In the Matter of Appointing a)
Local Public Health)
Administrator)

ORDER NO. 25-02

WHEREAS, ORS § 431.418(1) requires the Local Public Health Authority to appoint a qualified Local Public Health Administrator to supervise the activities of the Local Public Health Authority; and

WHEREAS, Kari Wilhite appears to the Board to meet the criteria as the Local Public Health Administrator and is willing and able to assume the duties contained in ORS § 431.418.

THE POLK COUNTY BOARD OF COMMISSIONERS ORDERS AS FOLLOWS:

(1) That Kari Wilhite be appoint as Polk County's Local Public Health Administrator.

(2) This order takes effect February 1, 2025

Dated: January 29, 2025 at Dallas, Oregon.

POLK COUNTY BOARD OF COMMISSIONERS

_____
Craig Pope, Chair

_____
Jeremy Gordon, Commissioner

_____
Lyle Mordhorst, Commissioner

Approved as to Form:

_____

County Counsel

CONTRACT REVIEW SHEET

Staff Contact: Rosana Warren | Phone Number (Ext): 2550

Department: Health Services | Consent Calendar Date: January 29, 2025

Contractor Name: PacificSource Community Solutions

Address: 3125 Chad Drive

City, State, Zip: Eugene, OR 97408

Effective Dates - From: March 01, 2025 | Through: December 31, 2026

Contract Amount: This contract is based on OHP enrollment and FFS - (Est Annual $12M)

Background:

PacificSource Community Solutions (PCS) through an agreement with Oregon Health Authority to be the Coordinated Care Organization (CCO) for the Marion-Polk Region and is responsible for implementing and administering Medicaid services. This Agreement is the renewal to Agreement No. 19-127. This Agreement may be modified from time-to-time throughout the fiscal year to reflect changes to funds and/or programs that are made a part of the CCO contract with OHA.

Discussion:

This Agreement is for the continuation of services Polk County has been providing as the Community Mental Health Program in the past fiscal years. This Agreement provides an increase to the WrapAround rate by $350 per enrolled member, which provides an average increase of $15,750 per month. This Agreement presents no other significant changes and extends the term date an additional 20 months.

Fiscal Impact:

This Agreement supports the current programming and staffing levels agreed upon and does not represent expansion at this time. The Behavioral Health and Public Health budgets were prepared in anticipation of this agreement being in place. This agreement will be modified throughout the year and a budget resolution may be needed at a later date.

Recommendation:

It is recommended that Polk County sign this Agreement with PacificSource Community Solutions.

Copies of signed contract should be sent to the following:

Name: Rosana Warren | E-mail: hs.contracts@co.polk.or.us

Name: | E-mail:

Name: | E-mail:

PARTICIPATING PROVIDER SERVICE AGREEMENT

This Provider Service Agreement is made and entered into as of this **1st day of March, 2025** ("Effective Date") by and between **PacificSource Community Solutions**, an Oregon non-profit corporation ("Health Plan"), and **Polk County**, ("Provider").

WHEREAS, Health Plan is, or is intending to be a company contracted with the State of Oregon, acting by and through the Oregon Health Authority ("OHA"), Health Systems Division ("HSD"), to implement and administer services under the Oregon Health Plan in certain counties in Oregon;

WHEREAS, Provider is either a) a provider who is HSD approved and duly licensed to practice his or her specialty in the State of Oregon, or b) a Provider entity who provides services under this Agreement through its partners, independent contractor(s), and/or employee(s), and/or c) Provider is a facility duly licensed by the state of Oregon for the care of patients, and meets the requirements of the state of Oregon laws for staffing and services to provide inpatient, outpatient, and/or emergency services;

WHEREAS, the parties mutually desire to enter into this Agreement to provide Covered Services to Health Plan Members under a Coordinated Care Organization Contract ("CCO Contract") with the OHA; and

WHEREAS, the parties intend that should any reasonable ambiguity arise in the interpretation of a provision of this Agreement, the provision shall be construed to be consistent with the legal requirements of the State of Oregon, the CCO Contract, or other legal requirements, as applicable.

NOW, THEREFORE, in consideration of the mutual covenants and agreements, the parties hereby agree as follows:

1.0 DEFINITIONS

1.1 Agreement. "Agreement" means this Participating Provider Agreement, including any and all recitals, amendments, exhibits, attachments, schedules, and addenda, now or hereafter entered into, between Provider and Health Plan.

1.2 Behavioral Health. "Behavioral Health" means mental health, mental illness, addiction disorders, and substance use disorders.

1.3 Clean Claim. "Clean Claim" means a claim received by Health Plan for payment of Covered Services rendered to a Member which can be processed without obtaining additional information from Provider or from a third party and has been received within the time limitations set forth herein. A Clean Claim does not include a claim from a Provider who is under investigation for fraud or abuse or a claim under review for Medical Necessity. A Clean Claim is a "clean claim" as defined in 42 CFR 447.45(b).

1.4 Coordinated Care Organization. "Coordinated Care Organization" ("CCO") means a corporation, governmental agency, public corporation, or other legal entity that is certified as meeting the criteria adopted by the Authority under ORS 414.572 to be accountable for care management and to provide integrated and coordinated health care for each of the organization's members.

1.5 Copayments. "Copayments" are defined as a fixed amount a Member is responsible to pay for a Covered Service, as may be provided in the Member's Health Benefit Plan.

1.6 Covered Services. "Covered Services" are defined as Medically Appropriate health services that are funded by the legislature of the State of Oregon and described in ORS 414.706 to 414.770; OAR 410-120-1210, Medical Assistance Benefit Packages and Delivery System; OAR 410-141-3860, Managed Care Prepaid Health Plan Provision of Health Care Services; OAR 410-141-3830, Prioritized List of Health Services; and OAR 410-141-3820, Oregon Health Plan Benefit Package of Covered Services; except as excluded or limited under OAR 410-141-3825, Excluded Services and Limitations for Oregon Health Plan clients and/or Division members; all as such statutes and rules exist today or as amended in the future.

1.7 Covering Practitioner. "Covering Practitioner" means a Health Plan Provider or, with prior Health Plan approval, a practitioner who is not a Health Plan Provider, who provides Covered Services to Members for or on behalf of Provider during an emergency or temporary unavailability such as a vacation or illness.

1.8 Emergency Services. "Emergency Services" are defined as Covered Services from a qualified provider necessary to evaluate or stabilize an emergency medical condition, including inpatient and outpatient treatment that may be necessary to assure within reasonable medical probability that the Member's condition is likely to materially deteriorate from or during a Member's discharge from a facility or transfer to another facility. OAR 410-120-0000(91).

1.9 Emergency Medical Condition. "Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such 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 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, serious impairment to bodily functions or serious dysfunction of any bodily organ or part. An Emergency Medical Condition is determined based on the presenting symptoms (not the final diagnosis) as perceived by a prudent layperson (rather than a health care professional) and includes cases in which the absence of immediate medical attention would not in fact have had the adverse results described in the previous sentence. OAR 410-120-0000(89). The decision of whether a condition requires Emergency Services rests with Health Plan and is subject to its procedures for post-treatment utilization review consistent with the standards under federal or Oregon law, as applicable.

1.10 Health Benefit Plan. "Health Benefit Plan" means the Benefit Package, as that term is defined in OAR 410-120-0000(34), of Covered Services under the Oregon Health Plan for which the Member is eligible.

1.11 Health Plan Provider Manual. "Health Plan Provider Manual" means a document developed and maintained by Health Plan, which provides instruction regarding standard

policy and procedural requirements of the Health Plan and is provided online on Health Plan's website in the provider section.

1.12 Health Plan Providers. "Health Plan Providers" means institutional or non-institutional health care entities or individuals that are under contract, directly or indirectly, with Health Plan to provider Covered Services to Members.

1.13 Medically Appropriate. "Medically Appropriate" means health services, items, or medical supplies that are:

(a) Recommended by a licensed health provider practicing within the scope of their license;

(b) Safe, effective, and appropriate for the patient based on standards of good health practice and generally recognized by the relevant scientific or professional community based on the best available evidence;

(c) Not solely for the convenience or preference of a Member or a provider for the service item or medical supply; and

(d) The most cost effective of the alternative levels or types of health services, items, or medical supplies that are Covered Services that can be safely and effectively provided to a Member in Health Plan's judgment. OAR 410-120-0000(145).

1.14 Member. "Member" means an individual who is found eligible by the Oregon Health Authority, including such divisions, programs, and offices as may be established therein, to receive services under the Oregon Health Plan, is enrolled with Health Plan and eligible to receive Covered Services, and to whom Provider is required to provide Covered Services pursuant to this Agreement.

1.15 Non-Covered Services. "Non-Covered Services" are defined as all health care services that are not Covered Services under the Member's Health Benefit Plan.

1.16 Oregon Health Authority. "Oregon Health Authority" is an Oregon state government agency.

1.17 Other Payor. "Other Payor" shall mean other payors for healthcare services, including but not limited to Health Plan subsidiaries, trusts, and governmental entities or authorized contracting entities or divisions, with whom Health Plan has entered into a contract.

1.18 Oregon Health Plan. "Oregon Health Plan" (OHP) means the Oregon Medicaid Demonstration Project, which expands Medicaid eligibility to eligible OHP clients (individuals found eligible by DHS to receive services under the OHP), as established by chapter 815, Oregon Laws 1993, and enacted during 1987, 1989, and 1991 legislative sessions, the goal of which is to ensure that Oregonians have access to health care coverage. OHP relies substantially upon prioritization of health services and managed care to achieve public policy objectives of access, cost containment, efficacy, and cost effectiveness in the allocation of health resources.

1.19 Substance Use Disorders. "Substance Use Disorders" means disorders related to the taking of a drug of abuse including alcohol, to the side effects of a medication, or to a toxin exposure. The disorders include substance use disorders, such as substance dependence and substance abuse, and substance-induced disorders, such as substance intoxication, withdrawal, delirium, dementia, and substance-induced psychotic or mood disorder, as defined in DSM-V criteria.

1.20 Urgent Care Services. "Urgent Care Services" are defined as Covered Services that are Medically Appropriate and immediately required to prevent a serious deterioration of a

Member's health that results from an unforeseen illness or an injury. OAR 410-120-0000(250). Services that can be foreseen by the individual are not considered Urgent Care Services.

2.0 PROVIDER RESPONSIBILITIES.

2.1 Provider Services and Requirements.

Provider shall:

(a) Provide or arrange for the provision of Covered Services to Members and beneficiaries of any Other Payor on an as-needed basis within the scope of Provider's licensing, training, experience, and qualifications and consistent with accepted standards of medical practice and the terms and conditions of this Agreement and any other applicable contract or similar arrangement.

(b) Provide Covered Services to the Members or beneficiaries of any Other Payor, pursuant to each applicable agreement between Health Plan and any Other Payor, and pursuant to and in accordance with the provisions of this Agreement.

(c) If Provider is a licensed facility, then facility shall provide inpatient and outpatient services, and/or Emergency Services for Members, as-needed. Facility shall practice within the scope of facility's license, training, experience, and qualifications, consistent with accepted standards of medical practice, and the terms and conditions of this Agreement. Facility shall not be required to provide any Covered Services to Members that facility does not customarily and routinely offer to other patients. Facility has the right to refuse to treat disruptive, disorderly, or dangerous Members according to the same standards and policies applied to its other patients.

(d) Devote sufficient time, attention, and energy necessary for the competent and effective performance of Provider's duties under this Agreement to Members who select Provider or are otherwise designated, assigned, or referred to Provider by Health Plan.

(e) Meet standards for timely access to care and services as specified in the CCO Contract and, when not specified in the CCO Contract, Oregon Administrative Rules, including 410-141-3515 and 410-141-3860.

(f) Meet the National Culturally and Linguistically Appropriate Services Standards (including mandatory training) established by the U.S. Department of Health and Human Services by providing 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.

(g) Ensure that its facilities under contract, if any, can meet cultural responsiveness and linguistic appropriateness standards in addressing the needs of adolescents, parents with dependent children, pregnant women, IV drug users, and Members with medication assisted therapy needs.

(h) Ensure the facility uses only certified or qualified interpreters for non-English speakers in all services, including dental services and non-urgent and urgent behavioral health treatments or interventions.

(i) Ensure providers and leadership, are educated on the importance of cultural responsivity, including plain language, diversity, equity and inclusion.

(j) Coordinate care with Member's assigned Patient-Centered Primary Care Home (PCPCH), if any, using electronic health information technology to the maximum extent feasible.

(k) Assist Health Plan Members gain access to social support services, including culturally specific community-based organizations, community based mental health services, DHS Medicaid-funded long term care services, and mental health crisis management services.

(l) Not seek payment from either Health Plan or Member for costs resulting from a Provider-Preventable Condition, as that term is defined in 42 CFR 447.26(b). Provider shall identify Provider-Preventable Conditions related to a Member to Health Plan and comply with all reporting requirements that OHA or Health Plan may require.

(m) Collaborate with Health Plan, the Community Advisory Council, and other stakeholders in completing a Community Health Assessment and Community Health Improvement Plan, and in carrying out activities to implement the Community Health Improvement Plan.

(n) Submit data pertinent to CCO quality improvement and incentive programs, complete patient experience surveys, share patient experience survey results with participating CCO entities, and participate in sharing of quality and performance data with participating CCO entities.

2.2 Personnel. If Provider is a licensed facility, then Provider shall devote sufficient time, attention, and energy necessary for competent and effective performance of Provider's duties under this Agreement to Members who select Provider or are otherwise designated, assigned, or referred to Provider by Health Plan. Provider will provide sufficient licensed and experienced personnel, will supervise their professional medical services, and will provide health care services at all agreed upon times and days to meet the needs of Members. All non-physician personnel reasonably required for the proper operation of Provider, including but not limited to licensed and non-licensed health care personnel and administrative personnel, shall be employed by or under contract with Provider. Provider shall be responsible for all compensation, benefits, and costs in connection with such personnel and be responsible in all respects resulting from the employment of or contracting with such personnel. Decisions with respect to hiring control, direction, and termination of such personnel shall be the sole responsibility of Provider.

2.3 Non-Discrimination. Providers shall not discriminate between Members and non-Members as it relates to benefits and services to which they are both entitled and shall ensure that Provider offers hours of operation to Members that are no less than those offered to non-Members as provided in OAR 410-141-3515.

Provider shall not discriminate in the treatment of Members based upon language, physical or medical disability, medical condition, race, color, national origin, ancestry, religion, sex, marital status, veteran status, sexual orientation, or age, to the extent prohibited by applicable federal, state, and local laws, regulations, and ordinances, and Provider shall provide services to Members in the same manner, in accordance with the same standards, and within the same availability as to non-Members.

2.4 Pre-authorization Program. Except for Emergency Services, Provider will fully cooperate with Health Plan's pre-authorization program. Health Plan will notify Provider in advance when Covered Services are added to, or removed from the pre-authorization program. Prior

approval of all procedures or services listed on the pre-authorization grid is required, and any claims submitted for such procedures without prior approval will be denied. The pre-authorization grid is provided within the provider section on the Health Plan's Community Solutions website.

2.5 Referrals. Except a) in the event of an emergency, b) where otherwise approved or directed in advance by Health Plan, or c) where a Member's medical needs otherwise require, Provider shall refer Members only to Health Plan Providers, and shall refer Members for hospital services only to Health Plan Provider hospitals. Provider shall comply with Health Plan's referral and authorization procedures as set forth in the Health Plan Provider Manual.

2.6 Emergency Coverage. Provider shall be responsible for responding to, or making arrangements for emergent needs of Members with respect to Covered Services twenty-four (24) hours per day, seven (7) days per week, including holidays. In the event that Provider is unable to provide required Covered Services, Provider shall arrange for a Covering Practitioner.

2.7 Billing Procedure.

(a) Covered Services; Hold Harmless. For all Covered Services provided by Provider under this Agreement, Provider shall bill and submit encounter data to Health Plan in accordance with OAR 410-141-3570 and the Health Plan Medicaid Provider Manual. Provider agrees to never, under any circumstances, including but not limited to, non-payment by Health Plan, insolvency of Health Plan, or the breach, expiration or termination of this Agreement, will Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against OHA, Members, or persons acting on Members' behalf, for Covered Services, and shall regard payment by Health Plan as payment in full for all benefits covered by this Agreement with the exception of Copayments specifically authorized in a Member's Health Benefit Plan. The obligations of this Section shall survive the termination of this Agreement regardless of the cause giving rise to termination. In addition, Provider shall not bill in any amount greater than would be owed if Provider provided the services directly, consistent with 42 CFR 438.106 and 42 CFR 438.230.

(b) Non-Covered Services. For all Non-Covered Services provided to any Member, Provider may bill Member directly for Non-Covered Services if prior to providing Non-Covered Services, Provider advised Member of non-coverage and Provider obtained Member's acknowledgment and acceptance of individual financial responsibility ("Agreement to Pay"). Such Agreement to Pay shall be obtained in writing in a form published by OHA in accordance with OAR 410-141-3565.

(c) Actions to Collect Amounts Owed. Provider shall not maintain any action at law or equity against OHA or any Member to collect any sum owed to Provider by Health Plan for Covered Services rendered pursuant to this Agreement. Provider shall not pursue legal or other remedy against Health Plan for nonpayment or underpayment to Provider for Covered Services provided to a Member unless and to the extent that Health Plan has failed to pay Provider for such Covered Services as required by this Agreement and Provider has exhausted any appeal rights or Health Plan becomes insolvent.

(d) Claims Policies and Procedures. Provider agrees to comply with claims policies and procedures as identified in the Health Plan Provider Manual, which shall be

consistent with industry standards for billing and coding practices. Provider agrees that claims must be submitted within four (4) months of the provision of services, except under the following circumstances: (a) billing is delayed due to eligibility issues; (b) pregnancy of the Member; (c) Medicare is the primary payer; (d) cases involving third party resources; (e) Covered Services provided by non-participating providers that are enrolled with OHA; or (f) other circumstances in which there are reasonable grounds for delay, as determined by Health Plan. Claims submitted after the applicable time period as specified in this Section will be denied, and Provider shall not seek reimbursement for such denied claims from Members. Provider agrees to abide by OHA's Provider-Preventable Conditions rules and requirements regarding non-payment of claims by Health Plan should preventable conditions occur.

(e) Bill Review. Provider agrees to cooperate with any requests by Health Plan, or its agent, to review any bills submitted by Provider to determine whether a bill submitted for services rendered to a Member is a Covered Service under the Member's Health Benefit Plan, subject to this Agreement, properly billed to the services provided (as reflected in the medical record), and that payments made to the Provider were accurate, in accordance with the terms and conditions set forth herein.

2.8 Compliance with Health Plan Policies and Procedures. Provider shall participate in, cooperate with, and comply with all applicable Health Plan requirements, policies, and procedures, including, but not limited to, those set forth in the Health Plan Provider Manual and those relating to Member grievances; credentialing; utilization review; quality assurance; information and document requests; requesting hospital admission or specialty services; medical records sharing for specialty treatments, at the time of hospital admission or discharge, and for after-hospital follow-up appointments; and medical management program(s). Health Plan agrees to make any such requirements, policies, and procedures available to Provider upon request within 72 business hours. Provider acknowledges that such Health Plan requirements and procedures may be amended from time to time. Provider acknowledges receiving, or having access to Health Plan's policies regarding Grievance, Notice of Adverse Benefit Determination, Appeals, and Contested Case Hearings, and access to the Health Plan Provider Manual.

2.9 Cooperation with UM and Quality Improvement Activities; Health Plan Committee and Corrective Action Plans. Provider agrees to cooperate with utilization management and quality management procedures specified by the OHA, or enacted by Health Plan and communicated to Provider by Health Plan. If Health Plan's quality review activities involve post-payment record reviews or audits, such activities shall be limited to Member records and shall be conducted at Health Plan's expense, not including the cost of accessing and/or copying records. Provider shall provide at no cost, up to 10 records per Provider per audit, after which the parties shall split the reasonable costs. Provider agrees to Health Plan's audit schedule, and Health Plan shall not unreasonably interfere with Provider's business operations for the purpose of such audit. Provider shall cooperate with Health Plan, or its designee, in the performance of quality improvement and related activities. Failure to comply with Health Plan utilization review requirements or respond to post-payment record reviews or audits may result in a Health Plan request for a return of monies paid to Provider. If such amounts are not refunded or a reasonable accommodation for repayment cannot be reached between Health Plan and Provider, Health Plan may setoff such monies against amounts owed to Provider. The setoff right provided above may only be exercised upon prior written notice to Provider. For any return requests or setoff notices, Provider shall be given an opportunity to be heard by Health Plan.

(a) Quality Improvement Programs. Provider will participate and/or promote applicable quality improvement programs, which are designed to improve the quality of care, quality of service, and the Member's experience. Such programs may include initiatives designed or required by regulatory or accreditation entities and may include without limitation data sharing via access to Provider's electronic health records, collection and evaluation of health data, providing access to supplemental data for collection of health data, providing applicable contact information to facilitate medical record chart chases, responding to Member complaints and quality of care concerns, responding to program evaluations and satisfaction surveys, and allowing Health Plan to use Provider performance data for quality improvement activities. Provider will also participate in CCO incentive measures which include data sharing via access to Provider electronic health records, participation in Health Plan incentive and improvement programs, and other measures or metrics as applicable.

(b) Corrective Action Plans. Health Plan, in its sole discretion, may determine that Provider'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 Provider'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 declare the need for corrective action and issue to Provider or request from Provider a corrective action plan ("CAP") subject to internal review and approval. Provider 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 Provider, and Health Plan may terminate this Agreement immediately or take other action including financial penalties, imposition of liquidated damages, or sanctions.

2.10 Provider Practice. Subject to the terms and conditions of this Agreement, Provider shall be entitled to perform all usual and customary procedures relative to their practice. This Agreement does not, and shall not be interpreted as, prohibiting or otherwise restricting Provider who is acting within the lawful scope of practice from advising or advocating on behalf of Members who are patients of such Provider, for the following:

(a) Members' 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 this Agreement or is subject to copayment;

(b) Any information Members need in order to decide among relevant treatment options;

(c) The risks, benefits, and consequences of treatment or non-treatment; and

(d) Members' right to participate in decisions regarding their health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

2.11 Professional Representations. Throughout the term of this Agreement, Provider represents and warrants that it shall comply with all of the following regards any licensed practitioners or Provider Entity covered under this Agreement:

(a) Maintain an unrestricted current license to practice his or her specialty under the State jurisdiction in which Covered Services are provided and have in effect at all times all licenses required by law for the practice of such provider's profession;

(b) Maintain credentialing according to NCQA credentialing standards either by Health Plan or Health Plan's agent;

(c) Secure and maintain, at Provider's expense, throughout the term of this Agreement, professional liability insurance in a minimum amount not less than the amounts specified in the Health Plan Provider Manual or as required by state law or OHA;

(d) Obtain and maintain staff privileges at the hospital primarily used by Health Plan Providers, assuming privileges are available and appropriate to that class of provider;

(e) Warrant that this Agreement has been executed by its duly authorized representative and that executing this Agreement and performing its obligations hereunder shall not cause Provider to violate any term or covenant of any other agreement or arrangement now existing or hereinafter executed; and

(f) Notify Health Plan promptly of any (i) modification, restriction, suspension, or revocation of any provider's authorization to prescribe or to administer controlled substances; (ii) imposition of sanctions against Provider under Medicaid, Medicare, or any other governmental program; or (iii) other professional disciplinary action or criminal or professional liability action of any kind against any provider, which is either initiated, in progress, or completed as of the Effective Date of this Agreement and at all times during the term of this Agreement

2.12 Facility Representations. If a facility, then throughout the term of this Agreement, Provider represents and warrants that Provider shall comply with all of the following regards all licensed facilities covered under this Agreement:

(a) Maintain all appropriate license(s) and certification(s) mandated by governmental regulatory agencies;

(b) Maintain accreditation by the Joint Commission on Accreditation of Healthcare Organizations ("Joint Commission") or another applicable accrediting agency recognized by Health Plan;

(c) Maintain compliance with all applicable federal and state laws and regulations related to this Agreement and the services to be provided hereunder, including, without limitation, statutes and regulations related to fraud, abuse, discrimination, disabilities, confidentiality, false claims, and prohibition of kickbacks;

(d) Establish and maintain an ongoing quality assurance/assessment program which includes, but is not limited to, appropriate credentialing of employees and subcontractors and shall supply to Health Plan the relevant documentation, including, but not limited to, internal quality assurance/assessment protocols, state licenses and certifications, federal agency certifications, and/or registrations upon request;

(e) Ensure that all ancillary health care personnel employed by, associated or contracted with Facility who treat Members are and will remain throughout the term of this Agreement appropriately licensed and/or certified as required by state law and supervised, and qualified by education, training and experience to perform their

professional duties; and will act within the scope of their licensure or certification, as the case may be;

(f) Maintain credentialing, privileging, and re-appointment procedures in accordance with its medical staffs by-laws, regulations, and policies, if any; meet the querying and reporting requirements of the National Practitioner Data Bank and Healthcare Integrity and Protection Data Bank ("HIPDB"); and fulfill all applicable state and Federal standards;

(g) Warrant that this Agreement has been executed by its duly authorized representative and that executing this Agreement and performing its obligations hereunder shall not cause Provider to violate any term or covenant of any other agreement or arrangement now existing or hereinafter executed; and

(h) Notify Health Plan promptly of any (i) modification, restriction, suspension, or revocation of Provider's license(s) and/or certification(s); (ii) imposition of sanctions against Provider under the Medicaid program, Medicare program, or any other governmental program; or (iii) other disciplinary action, or criminal or professional liability action of any kind against Provider, which is either initiated, in progress, or completed as of the Effective Date of this Agreement and at all times during the term of this Agreement.

2.13 Credentialing. Provider and practitioners covered under this Agreement agree to comply with credentialing requirements of Health Plan as outlined in the Health Plan Provider Manual and prior to rendering of Covered Services to Members. Provider warrants that it and any practitioner affiliated with Provider meets Health Plan's credentialing standards and that Provider has all licenses, permits, and/or governmental or board authorizations or approvals necessary to provide Covered Services in accordance with the applicable requirements in the state(s) in which Provider conducts business. Provider will provide immediate written notice to Health Plan of any changes in the licenses, permits, and/or governmental or board authorizations or approvals referenced above.

2.14 Provider Information. Provider shall notify Health Plan of any change in Provider information, including but not limited to, address, phone number, tax identification number, open and closed practice status, board certification and hospital privileges in advance of said change. Provider hereby authorizes any and all hospitals that Provider maintains staff privileges at to notify Health Plan promptly following the initiation of any disciplinary or other action of any kind that could result in any suspension, termination, or restriction in any material way, which would affect the ability of Provider to provide Covered Services to Members.

2.15 Coordination of Benefits. Provider agrees to (a) cooperate in providing for effective implementation of the provisions of all Health Benefit Plans and Health Plan policies relating to coordination of benefits and (b) comply with coordination of benefits policies described in the Health Plan Provider Manual. Provider shall inform Health Plan and OHA if Provider learns that a Member has insurance or health care benefits available from other sources or if a Member's condition is the result of other party liability. Provider will cooperate with Health Plan in pursuing claims against such other payors. In the event of illness or injury for which a third party has accepted financial responsibility or has been judged to be liable, the amount available for collection by Provider from the third party shall be applied to charges for medical care of the Member prior to the resources of Health Plan.

If the third party has reimbursed Provider, or if a Member reimbursed Provider after receiving payment from the third party, then Provider must reimburse Medicare up to the full amount Provider received, if the Member has Medicare and if Medicare is unable to recover its payment from the remainder of the third party payment. If the third party is not liable for the

illness or injury of a Member or if recovery from the third party is less than Health Plan's obligation to the Member in the absence of payment by a third party, Provider shall comply with Health Plan's rules governing the provision of Covered Services and the terms of this Agreement in order for Health Plan to accept financial responsibility. Notwithstanding the foregoing, Provider may not refuse to provide Covered Services to a Member because of a potential third party liability, but shall provide Covered Services and cooperate with Health Plan for possible recoupment of funds.

2.16 Health Plan Provider Directory. Provider hereby authorizes Health Plan to list Provider's name, specialty, address, telephone number, and if Provider is accepting new patients in Health Plan's Provider Directory, whether on-line or in print, and in any Health Plan materials to help promote Health Plan or Health Benefit Plans to Members.

2.17 Provider Entities. If Provider is a Provider Entity, Provider shall provide services under this Agreement solely through its individual practitioner shareholders, partners, independent contractors, and/or employees and must ensure that all such shareholders, partners, independent contractors, and/or employees comply with the terms of this Agreement.

2.18 Confidentiality. During and after the term of this Agreement, Provider shall keep confidential any financial, operating, proprietary, or business information relating to Health Plan that is not otherwise public or reasonably identified as confidential, including but not limited to, the terms of this Agreement. The obligations of this Section shall survive the termination of this Agreement.

2.19 Non-Solicitation. Provider shall not directly or indirectly engage in Disparagement, as defined below, of Health Plan to any Member without Health Plan's prior written consent. For the purposes of this Section, "Disparagement" shall mean any oral or written statement that is slanderous, defamatory, or intentionally inaccurate, regarding Health Plan that may be reasonably interpreted to be intended to persuade any Member or employer of such Member to disenroll from a Health Benefit Plan or to encourage any Member or employer of such Member to receive health care from Provider other than pursuant to this Agreement. Nothing in this section is intended to interfere with an Provider's ability to communicate with a Member about the Member's medical condition, proposed treatment, or treatment alternatives whether covered by Health Benefit Plan or not and is consistent with state or federal laws. In addition to any other remedy available at law or in equity, Provider's breach of this Section shall be grounds for termination, pursuant to Section 4.5 (Termination with Cause upon Notice) of this Agreement, from participation in Health Plan's panel of Health Plan Providers and from participation in providing Covered Services to Members in accordance with the terms and conditions of this Agreement.

2.20 Eligibility Verification. Providers will verify eligibility, and Member assignment prior to the provision of Covered Services. Provider acknowledges that failure to verify eligibility may result in denial of claims for Covered Services.

2.21 Appointment Availability. Provider shall report appointment availability using a format consistent with OHA requirements and provided by Health Plan. Provider shall provide or otherwise make available timely treatment to each Member in accord with the CCO Contract,

and if not addressed in the CCO Contract, as identified in OAR 410-141-3515 and as later amended or superseded.

2.22 Pricing and Quality Transparency. To the extent required by Oregon law, Provider shall promptly provide pricing and quality information to Health Plan as requested for the purpose of providing cost estimates to Members.

2.23 Emergency Room Referrals. Providers shall (a) not refer or direct Members to hospital emergency rooms for non-Emergency Medical Conditions and (b) educate and instruct Members in the proper utilization of Provider's office in lieu of the hospital emergency room.

2.23 Subrogation. As required by Health Plan's contract with OHA, Provider agrees to subrogate to OHA any and all claims Provider has or may have against manufacturers, wholesale or retail suppliers, sales representatives, testing laboratories, or other providers in the design, manufacture, marketing, pricing, or quality of drugs, pharmaceuticals, medical supplies, medical devices, DMEPOS, or other products.

2.24 Electronic Medical Record Access. Upon request, Provider agrees to allow Health Plan access to Provider's electronic medical record system for the retrieval and review of Member medical records. Such access will be granted on a continuous basis for the duration of this Agreement and Health Plan will agree to reasonable restrictions and rules related to such access.

2.25 Representations and Warranties. Provider represents and warrants that (a) it has the power and authority to enter into and perform this Agreement, (b) this Agreement, when executed and delivered, shall be a valid and binding obligation of Provider enforceable in accordance with its terms, (c) Provider has the skill and knowledge possessed by well-informed members of its industry, trade or profession and Provider will apply that skill and knowledge with care and diligence to perform the services contemplated herein in a professional manner and in accordance with standards prevalent in Provider's industry, trade or profession, and (d) Provider shall, at all times during the term of this Agreement, be qualified, professionally competent, and duly licensed to perform the services contemplated herein.

3.0 HEALTH PLAN RESPONSIBILITIES

3.1 Payment. Provider shall be compensated for Covered Services provided to Members in accordance with Attachment A. Unless a claim is disputed, Health Plan shall approve payment(s) for Provider's complete, accurate, and timely submitted Clean Claims for Covered Services rendered to a Member, in accordance with Health Plan policies or applicable laws or regulations. The timing and calculation of payment(s) to Provider for Covered Services shall be according to Health Plan's payment methodology as set forth in this Agreement and Attachment(s).

3.2 Refunds. Health Plan may initiate refunds from Provider for up to one (1) year from the date of payment. Refund statements are generated on a monthly basis, and Health Plan will setoff consistent with Section 2.9 (Cooperation with UM Quality Improvement Activities; Health Plan Committee and Corrective Action Plans). In the event that HSD retroactively disenrolls a Member, Health Plan reserves the right to initiate provider refunds for any applicable time period, which may be longer than one (1) year from the date of payment.

3.3 Oregon Health Plan/OHA Possible Revision / MLR-based Repayment to OHA. In the event of a revision to premium levels for OHP members by the State of Oregon/OHA by a net amount deemed by Health Plan to be inconsistent with the (a) primary care provider

capitation rate, or (b) professional conversion factors agreed to in this Agreement; PacificSource will notify Provider of such inconsistency in writing, and both parties will enter into a renegotiation of reimbursement rates to achieve consistency with any new Oregon/OHA premium levels to Health Plan.

In the event OHA determines Health Plan must pay OHA any sum because the 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 the Health Care Budget, or (b) make direct investments to increase the MLR and offset such expenses with the settlement, upon communication with Provider and the CCO Health Council.

3.4 Member Eligibility. Health Plan shall establish a method for Provider to identify whether a person requesting services is enrolled with Health Plan and eligible to receive Covered Services paid for by Health Plan.

3.5 Subcontracts. Health Plan may subcontract any or all of the services Health Plan agrees to provide under this Agreement. No subcontract shall terminate or limit Health Plan's legal responsibility for the timely and effective performance of its duties and responsibilities under this Agreement.

3.6 Marketing. Health Plan may advertise the participation of Provider with Health Plan in print, voice, and video advertising media. Health Plan may list the name, address, telephone number, and other identifying information of Provider in Health Plan's publications furnished to Providers and Members and may identify Provider as a Health Plan Provider in advertising and marketing materials, in accordance with OHA guidelines.

3.7 Choice of Health Care Provider. Health Plan will allow Member to choose his or her health care provider to the extent possible and appropriate.

3.8 Member Assignment. Health Plan and Provider may, upon mutual determination, modify Member assignment/attribution to primary care providers. Re-assignments may be made in response to objective data related to quality performance, patient experience, access, or in response to other information available to Health Plan. Health Plan may make individual Member assignment changes pertaining to patient access, in situations of immediate need, and will communicate such changes to Provider within five (5) days of the change. If Health Plan changes to primary care provider assignment more than two (2) times per month, then Health Plan will provide a report detailing the need for change, the individual Provider from whom the Member was removed as their primary care provider, and the individual Provider to whom the Member was moved to as their primary care provider.

4.0 TERM AND TERMINATION.

4.1 Term and Renewal. The term of this Agreement shall begin on the Effective Date and shall continue for an initial term of one (1) year. Thereafter, this Agreement shall automatically renew for additional one (1) year periods until terminated in accordance with this Section.

4.2 Termination without Cause. Either party may terminate this Agreement at any time upon at least one hundred eighty (180) days prior written notice to the other party.

4.3 Immediate Termination. Health Plan shall have the right to terminate this Agreement immediately by written notice to Provider upon the occurrence of any of the following events:

(a) Provider's license to provide medical services in the state in which services were rendered, as applicable, or authorization to administer controlled substances is terminated, suspended, or restricted in any material way, which would affect the ability of Provider to furnish Covered Services to Members pursuant to the terms of this Agreement;

(b) Provider's medical staff privileges at any licensed general acute care hospital is suspended, terminated, or restricted in any material way, which would affect Provider's ability to provide Covered Services to Members;

(c) Provider is suspended from participation in Medicaid or Medicare programs or not enrolled as a Medicaid Provider with the State of Oregon;

(d) Provider's loss of professional liability coverage as required by this Agreement;

(e) Provider's death or incapacity. Health Plan reserves the right to determine whether Provider is incapacitated for the purposes of this Section;

(f) Provider fails to comply with the notification requirements set forth in this Agreement;

(g) Health Plan makes a reasonable and good faith determination that such termination is necessary to protect the health or welfare of Members; or

(h) If Provider is a Provider Entity, Provider (i) ceases to be a professional corporation, medical group partnership, or other health care provider organization in good standing under the laws of the state in which Covered Services were rendered, as applicable, or (ii) there is a change in the majority ownership or control of Provider; or (iii) Provider violates the drug-free workplace provisions in this Agreement.

To protect the interests of Members, Provider will provide immediate notice to Health Plan of any of the aforesaid events. Health Plan shall provide Provider an opportunity to respond to Health Plan's termination decision if the basis for Health Plan's termination decision is based upon mistaken or otherwise erroneous information, and shall otherwise follow any legal requirements that apply.

4.4 Immediate Termination of Licensed Facility. Health Plan shall have the right to immediately terminate this Agreement by written notice to any licensed facility upon the occurrence of any of the following events:

(a) Withdrawal, expiration, or non-renewal of any Federal, state, or local license, certificate, approval or authorization of Provider;

(b) Bankruptcy or receivership of Provider, or an assignment by Provider for the benefit of creditors;

(c) Loss or material limitation of Provider's insurance;

(d) Debarment or suspension of Provider from participation in any governmental sponsored program, including, but not limited to Medicare;

(e) Failure to comply with the notification requirements set forth in this Agreement, including those in Section 2.11 and 2.12;

(f) Revocation or suspension of Provider's accreditation as required in this Agreement;

(g) The listing of Provider in the HIPDB; or

(h) Change of control of Provider to an entity not acceptable to Health Plan, or there is a change in the majority ownership or control of Provider.

To protect the interests of Members, Provider will provide immediate notice to Health Plan of any of the aforesaid events. Health Plan shall provide Provider an opportunity to respond to Health Plan's termination decision if the basis for Health Plan's termination decision is based upon mistaken or otherwise erroneous information, and shall otherwise follow any legal requirements that apply.

4.5 Termination with Cause upon Notice. Health Plan may terminate this Agreement for cause, including, without limitation, quality of care, fraud, waste or abuse concerns, from participation in Health Plan's panel of Health Plan Providers and in the provision of Covered Services to Members pursuant to the terms and conditions of this Agreement. For cause shall not include a Provider advocating a decision, policy, or practice solely for reason of such advocacy. In the event of a termination for cause, Provider is entitled to those rights of appeal as described in Health Plan's Appeal Process for Terminated Providers Policy.

4.6 Rights and Obligations upon Termination.

(a) Continuation of Obligations. Upon termination, all rights and obligations of the parties under this Agreement shall immediately cease, except those rights and obligations that are identified as surviving the term of this Agreement. Termination of this Agreement shall not relieve either party of any obligation to the other party in accordance with the terms of this Agreement, and with respect to services furnished prior to such termination, and shall not relieve Provider of Provider's obligation to cooperate with Health Plan in arranging for the transfer of care of Members receiving treatment from Provider.

(b) Continuation of Services. If required by a Health Benefit Plan, and unless Health Plan makes provision for the assumption of such services by another practitioner, following termination of this Agreement, Provider shall continue to furnish, and Health Plan shall continue to pay for, in accordance with the terms of this Agreement, Covered Services rendered to Members under the care of Provider at the time of termination until the services being rendered are completed. Health Plan shall use its best efforts to arrange for any Members under the care of Provider at the time of termination of the Agreement to be transferred to another Health Plan Provider at the earliest possible date. In the event of termination of this Agreement, Provider shall cooperate with and not interfere in the transfer of Members under the care of Provider at the time of termination until the services being rendered are completed.

(c) Access to Records Upon Termination. Notwithstanding any termination of this Agreement, Provider shall continue to provide Health Plan access to Provider's records, so as to allow Health Plan to continue to meet its obligations under the CCO Contract.

5.0 OREGON HEALTH PLAN PROVISIONS

5.1 Accountability. Provider acknowledges that Health Plan oversees and is ultimately accountable to OHA for the timely and effective performance of Health Plan's duties and responsibilities under Health Plan's contract with the State of Oregon, acting by and through OHA.

5.2 Continuation of Services. In the event of insolvency or cessation of operations of Health Plan, Provider shall continue to provide Covered Services to Members for the period in which Health Plan continues to receive compensation for administering services under the Oregon Health Plan.

5.3 Incorporation of Provisions. To the extent that any provision of Health Plan's CCO Contract to implement and administer services under the Oregon Health Plan applies to Provider with respect to the services contemplated hereunder, such provision shall be incorporated by this reference into this Agreement and shall apply equally to Provider.

6.0 GENERAL PROVISIONS.

6.1 Reimbursement; Value-Based Payments. The parties recognize the CCO Contract requires transition to value-based payments. Provider agrees to make best efforts to establish and implement value-based payments Health Plan that fulfill the requirements of the CCO Contract, including performance measures determined by OHA. Further, the parties agree to make best efforts to expand value-based payments Health Plan annually to fulfill the requirements of the CCO Contract and value-based payment requirements.

6.2 Non-Exclusivity. This Agreement is not exclusive, and nothing herein shall preclude either party from contracting with any other person or entity. Health Plan makes no representation or guarantee as to the number of Members who may select Provider for the purpose of receiving Covered Services.

6.3 No Third Party Beneficiaries. Neither Members nor any other third parties are intended by the parties to this Agreement to be third party beneficiaries under this Agreement, and no action may be brought to enforce the terms of this Agreement against either party by any person who is not a party to this Agreement.

6.4 Indemnification. At all times during the term of this Agreement, Provider shall indemnify, defend, and hold Health Plan and Health Plan's employees and agents harmless from and against any and all claims, damages, causes of action, costs, or expenses, including reasonable attorneys' fees, to the extent proximately caused by the gross negligence or willful misconduct of Provider or any employee or agent of Provider's arising out of this Agreement. At all times during the term of this Agreement, Health Plan shall indemnify, defend, and hold Provider and Provider's employees and agents harmless from and against any and all claims, damages, causes of action, costs or expenses, including reasonable attorneys' fees, to the extent proximately caused by the gross negligence or willful misconduct of Health Plan or any Health Plan employee or agent arising from this Agreement. Notwithstanding the foregoing, this Section shall be null and void to the extent that it is interpreted to reduce insurance coverage to which either party is otherwise entitled, by way of any exclusion for contractually assumed liability or otherwise.

6.5 Dispute Resolution. Notwithstanding any other provision in this Agreement, and unless otherwise required by federal law, the parties agree to resolve disputes related to the termination or non-renewal of this Agreement in the manner set forth in OAR 410-141-3560, as that regulation now exists or is amended.

6.6 Assignment. Neither party may assign or transfer its rights or obligations under this Agreement without the prior written consent of the other; provided, however, that Health Plan may assign this Agreement, upon thirty (30) days prior written notice, to any entity that controls, is controlled by, or that is under common control with Health Plan now or in the future, or which succeeds to its business through a sale, merger, or other corporate

transaction without the prior consent of Provider. Any purported assignment or transfer in violation of this Section 6.6 shall be null and void.

6.7 Amendments. Health Plan may amend this Agreement by providing prior written notice to Provider. Failure of Provider to object in writing to any such proposed amendment within thirty (30) days following receipt of notice shall constitute Provider's acceptance thereof. Any amendment to this Agreement or Exhibits necessary for compliance with state or federal law or regulation shall become effective upon notice from Health Plan to Provider if required by federal or state law. In the event Provider objects to such amendment necessary for compliance with state or federal law, Health Plan may, at its sole option, either continue this Agreement unamended or terminate this Agreement sixty (60) days from the date of receipt of written objection from Provider. During said sixty (60) day period, the terms and conditions of this Agreement as existed on the day prior to the date of the written objection, including all terms and conditions of compensation, shall continue to be in effect. If amendment is to comply with state or federal law, termination of this Agreement under this provision shall be treated as a "voluntary termination" without right to hearing. Notwithstanding the foregoing, this Agreement may be amended at any time by mutual written agreement signed by both parties.

6.8 Headings. The headings of the various sections of this Agreement are merely for convenience and do not, expressly or by implication, limit, define, or extend the terms of the sections to which they apply.

6.9 Notices. Any notice required to be given pursuant to the terms of this Agreement shall be in writing and shall be either hand delivered, sent via facsimile, sent via overnight mail (such as Federal Express), or sent postage prepaid, by certified mail, return receipt requested, to Health Plan or Provider at the address set forth on the signature page of this Agreement. Such address may be changed by giving notice of such change in the manner provided in this Section for giving of such notice. The notice shall be effective on the date of delivery if delivered by hand or sent via facsimile, the date of delivery as indicated on the receipt if sent via overnight mail, or the earlier of the date indicated on the return receipt or four (4) business days after mailing if sent by certified mail.

6.10 Severability; Conformity with Law. If any provision or Oregon Administrative Rule (OAR) defined in this Agreement is declared invalid or otherwise unenforceable, the enforceability of the remaining provisions shall be unimpaired, and the parties shall replace the invalid or unenforceable provision or OAR with a valid and enforceable provision or OAR that reflects the original intention of the parties as nearly as possible in accordance with applicable law. This Agreement shall be interpreted and, if necessary, amended to conform with applicable federal and state law in effect on or after its Effective Date.

6.11 Waiver of Breach. The waiver of any breach of this Agreement by either party shall not constitute a continuing waiver or a waiver of any subsequent breach of either the same or any other provision of this Agreement.

6.12 Modification of Health Benefit Plan. Health Plan may change, revise, modify, or alter the form or content of any Health Benefit Plan or Member written materials without prior approval or notice to Provider.

6.13 Conflict with Health Benefit Plan; Outside Contracts. This Agreement does not modify the benefits, terms, or conditions contained in a Member's Health Benefit Plan. In the event of a conflict between this Agreement and the terms of the Member's Health Benefit Plan, the terms of the Member's Health Benefit Plan shall control. Health Plan does not and shall not

prohibit a Member from contracting for services outside the Member's Health Benefit Plan; however, Health Plan does not consent to, or agree to be bound by, any terms or conditions that may be offered to, or entered into by, any Member contracting outside of their Health Benefit Plan

6.14 Conflict with Health Plan Provider Manual. In the event the terms and conditions of this Agreement conflict with the terms and conditions of the Health Plan Provider Manual, the terms and conditions of this Agreement shall control.

6.15 Governing Law. This Agreement shall be construed and enforced in accordance with the laws of Oregon.

6.16 Entire Agreement. This Agreement and any and all recitals, amendments, exhibits, attachments, schedules, and addenda in addition to the Health Plan's Policies and procedures contained in the Health Plan Provider Manual contain the entire agreement of the parties, and supersede any other agreement between the parties for Medicaid.

IN WITNESS WHEREOF, the parties have executed this Agreement as of the Effective Date.

HEALTH PLAN:		**PROVIDER:**	
PACIFICSOURCE COMMUNITY SOLUTIONS		**POLK COUNTY**	
By:	_____	By:	_____ (Signature)
Name:	Peter McGarry	Name:	_____
Title:	Vice President – Provider Network	Title:	_____
Date:	_____	Date:	_____
Address:	PO Box 7068 Springfield, OR 97475-0068	Address:	182 SW Academy St., Ste. 302 Dallas, OR 97338
Email:	ORContracting@pacificsource.com	Email:	carroll.noelle@co.polk.or.us

Attachment A-1

Polk County

March 1, 2025

Reimbursement Schedule – Risk/Incentive Model

Community Mental Health Program

1.0 RISK/INCENTIVE MODEL.

The Risk/Incentive model agreed upon by Health Plan and Provider shall contain the following:

(A) A risk/incentive model involving multiple community Health Care Budgets for populations of Members assigned to specific physical health primary care providers, derived from revenue allocated for the physical health and behavioral health care needs of Members, and a settlement for providers with budget-based aligned incentives as indicated in this Attachment A.

(B) Fee-for-service payment for professional services provided by Provider with a Claims Risk Withhold, in addition to program-based PMPM reimbursement where appropriate.

(C) For distinct OHP Member populations assigned to physical health primary care providers with risk/incentive models in their agreements with Health Plan. A risk/incentive model which features Revenue and Expenses for physical health and behavioral health professional and residential services under OHP and paid by the State of Oregon to Health Plan as a global capitation payment, and less revenue reductions pertaining to (i) Hepatitis C reconciliations (as reconciled with the State of Oregon if necessary), (ii) HRA adjustments, taxes, premium transfers and other OHA mandated premium reductions, and (iii) excluding Revenue and Expenses in the following categories:

- State of Oregon mandated spending/expenses on social determinants of health.
- "Dental Care" premium allocation and expenses until such time as this premium and expenses are added to risk model described here.
- "Non-Emergent Medical Transportation" premium allocation and expenses.
- CCO Quality Incentive Measure ("QIM") withhold return from the State of Oregon received in the year of settlement, whose distribution methodology is excluded as determined by the CCO Health Council.
- Operating payments to the CCO Health Council, taxes, adjustments and premium transfers.

(D) Contract terms that are consistent with the Joint Management Agreement (JMA) and JMA budget signed between Health Plan and the CCO Health Council 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.

(E) Metrics which specify the return of part or all of the Risk Withhold and Surplus which may result from health care expenses measured against the HCB.

2.0 COMPENSATION.

2.1 Fee For Service Reimbursement

SERVICE/PROCEDURE	MAXIMUM ALLOWABLE	PERFORMANCE WITHHOLD
Outpatient Mental Health/Substance Use Disorder Services: 90785, 90832-90834, 90836-90840, 90846, 90847, 90849, 90853, 90882, 90887, H0032, T2010, T2011, T1023, H0002, H0004, H0005, H0006, H0020, H0022, H0033, T1006	138% of OHP Allowable[1, 2, 3]	10%
Outpatient Behavioral Health Assessments: 90791, 90792, 96130-96133, 96136, 96137, H0001, H0031, H2000	170% of OHP Allowable[1, 2, 3]	10%
Evaluation and Management Services: 99202-99205, 99211-99215, 99354, 99355, 99341-99345, 99347-99350	170% of OHP Allowable[1, 2, 3]	10%
ABA Therapy Services	100% of OHP Allowable[1, 2]	10%
THW Services: Consistent with PacificSource guidelines	100% of OHP Allowable[1, 2, 3]	10%
Laboratory, DME: Services listed in the OHP Medical-Dental Fee Schedule	100% of OHP Allowable[1, 2]	10%
Injectables, Vaccines, Immunizations: Services listed in the OHP Medical-Dental Fee Schedule	100% of Billed Charges	10%
Services and procedures not otherwise listed in this Attachment Services listed in the OHP Behavioral Health Fee Schedule Services listed in the OHP Medical-Dental Fee Schedule	 100% of OHP Allowable[1, 2] 100% of OHP Allowable[1, 2]	 10% 10%
Services and procedures without an established unit value listed above: PacificSource Health Plans may establish such unit	PacificSource Community Solutions Default Fee Allowance[4]	10%

values for purposes of its Maximum Allowable rate determination.		

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

1. PacificSource will reimburse based on the rates published as of the date of adjudication.
2. Updates to the schedules noted above shall be updated in accordance with OHP.
3. OHP Behavioral Health Fee Schedule is primary, OHP Medical-Dental Fee Schedule is secondary.
4. PacificSource utilizes industry standard publications and rate methods to supplement codes not established by the above noted methodologies.

2.2 Program-Based Reimbursement

Reimbursement for the services and programs defined below will be calculated as a per-member per-month (PMPM) payment based on full CCO (not county-specific) membership eligible for behavioral health benefits. The PMPM payment will be made prospectively based on the rates listed below with retroactive reconciliation as described below completed by Health Plan based on quarterly Provider reports using Health Plan's reporting template.

Services and Programs	Unit of Measure	$ per Unit
Youth Fidelity Wraparound Program (inclusive of all services, including those sub-contracted)	Per-Member Per-Month	$1,450[1]

1. On or before the 5th of the month, Provider shall send an invoice to Health Plan for Children's Wraparound Care Coordination. The invoice must include members served in the previous month and include the following data:

- Member name
- Member date of birth
- Medicaid ID number

Services and Programs	Unit of Measure	$ per Unit	Actual Payment Per Unit or PMPM
Professional Supervision for Licensure	Per supervision Session (60/45/30 minute increments), paid quarterly	60 = $435.55 45 = $295.89 30 = $200.65	
Assertive Community Treatment	Per member per month		$2,262
System Planning and Inter-Agency Coordination	Per member per month		$0.13
Community Support Services (CSS) Total	Per member per month		$2.26
Total Program Support			**$2.39**

Allocation of payment for Community Support Services			
Crisis (including Mobile)	Per member per month		$0.67
Supported Employment-Education	Per member per month		$0.34
Early Psychosis including EASA	Per member per month		$0.22
Intensive Children's Services	Per member per month		$0.12
Other CSS:	Per member per month		$0.91

Services and Programs	Description, Conditions, and Reporting
Youth Fidelity Wraparound Program	Condition: Fidelity to OHA model Reporting: Monthly enrollment and enrollee encounters. On or before the 5th of the month, Provider shall send an invoice to Health Plan. This invoice shall indicate members served in a previous month and include the following data: • Member name • Member date of birth • Member identification number Payment: Health Plan shall verify member eligibility and coverage, prorating the monthly rate should the member have not been eligible for services for the entire month. Provider will submit additional data elements as determined by Health Plan in order to verify the services rendered and member eligibility.
Professional Supervision for Licensure	Description: Registered Associate is defined as individual who has completed education requirements and registered with their respective licensing board as they complete clinical hours for licensure. To quality for payment, Registered Associates must be employed by Provider and have entered into a board-approved supervisory agreement with a Clinical Supervisor employed by a Provider. Reporting: Provider shall submit supervision log for supervision hours provided to Registered Associates on or before 15 days following quarter's end. Annually (on or before January 15th), provider will submit roster of Registered Associates that Provider staff had supervision agreements with in prior year. Provider will include the supervision agreement for each Registered Associate listed. Payment: Payment is calculated by estimating potential revenue lost due to Clinical Supervisor and Registered Associate not being able to bill for psychotherapy services during supervision time. Payment may be recouped if evidence of a supervision agreement between the Registered Associate and Clinical Supervisor is not provided.
Assertive Community Treatment (ACT)	Reporting: Monthly enrollment and enrollee encounters. Provider shall send an invoice to Health Plan n or before the 5th of the month. This invoice shall indicate members served in a previous month and include the following data: • Member name • Member date of birth • Member identification number

Services and Programs	Description, Conditions, and Reporting
	Payment: Health Plan shall verify member eligibility and coverage, prorating the monthly rate should the member have not been eligible for services for the entire month. Provider will submit additional data elements as determined by Health Plan in order to verify the services rendered and member eligibility.
Community Support Services (CSS) Total	Reporting: Actual expenditures, enrollment, performance, and outcomes. Payment: Allocation of Program Support payment across CSS may be recalculated during the third quarter of each calendar year based on Provider's prior fiscal year budget and actual financials.

The following codes will be encountered at 100% of OHP fee schedule but not paid because payment is included in the Services and Program payments detailed above:

Services and Programs	Codes
Youth Fidelity Wraparound	H2021, H2022
Fidelity Assertive Community Treatment	H0039
Day Treatment	H0036
Crisis	
Early Psychosis including EASA	
Peer Support Services	H0038
Supported Employment/Education	H2023
Intensive Children's Services	
Additional Community Support Services	G0176, G0177, H0034, H0046, H2010, H2018, H2027, H2032, H2033, T1016

2.3 Performance Withhold Return Contingent On Quality

One hundred percent (100%) of any Provider's Performance Withhold return will be paid contingent on the performance of the performance measures defined in this Attachment, some of which are established and measured by the State of Oregon for the entire CCO and will be awarded based on such State of Oregon measurement and State of Oregon final payment for the CCO.

3.0 SETTLEMENT PERAMETERS.

3.1 Settlement Parameters

The following settlement parameters for this section pertain for OHP members assigned to Provider.

3.2 Time Period.

Annual Performance Withhold settlement will occur for the calendar year in the month of August after the close of the contract period ending December 31st. Performance Withhold return will be made to Provider in the month of August after final OHA determinations of QIM revenue determinations.

3.3 Performance Withhold Settlement Summary.

Health Plan shall be responsible for computing, documenting, and reporting to Provider an annual Performance Withhold settlement summary. This report shall be submitted to Provider in the month of August after year-end.

3.4 Budget Surplus or Deficit

For the contract period for the experience of Members assigned to any physical health primary care provider with a risk/incentive model in their agreement with Health Plan, the Health Care Budget will be compared to actual expenses incurred to determine whether a Surplus or Deficit exists.

3.4.1 Value Based Payment.

Provider will cooperate with Health Plan in complying with OHA requirements for value-based payments in the areas of: Maternity, Hospital, Pediatric, Behavioral Health and Oral Health care. As such, Performance Withhold return may be contingent on a specific array of metrics pertaining to these OHA-required areas as determined by Health Plan and Provider.

3.4.2 Unearned Performance Withhold

Any Unearned Performance Withhold shall be allocated in the following order:

1st Used to contribute to Health Plan's limited margin, consistent with the limitation in the Joint Management Agreement (JMA) between Health Plan and the CCO Health Council.

2nd Any remaining Unearned Performance Withhold Payment will be treated as shared savings under the terms of the JMA.

4.0 PERFORMANCE MEASURES AND REPORTING.

4.1 Performance Measures

Any Performance Withhold Distribution to Provider shall be based on the below, with the weight of each performance measure representing the percentage of return to be paid based on achieving the measure.

4.2 Performance Reports

Performance measure reports from Provider shall be submitted using Health Plan's ShareFile site by 11:59pm on the due date stated. Late submissions will incur a 25% penalty on weighted performance withhold value per partial or full week that reporting is submitted after the due date.

#1: Measures TBD	
Goal	
Weight	
Reporting	
Target	
Numerator	
Denominator	

#2: Measures TBD	
Goal	
Weight	
Reporting	
Target	
Numerator	
Denominator	

5.0 GENERAL PROVISIONS.

5.1 Requirements

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

Provider allow Health Plan to share individual provider performance with CCO Health Councils.

Provider will collaborate with Health Plan to gain consensus through the CCO Health Council on maximizing and distributing Quality Pool funds from OHA.

Provider will collaborate with Health Plan to comply with the OHA Health Plan Quality Metrics Committee (HPQMC), with Health HPlan responsible for describing quality metrics from the HPQMC that will be used.

Provider will collaborate with Health Plan to comply with OHA's Practitioner Incentive Plan (PIP) reporting.

Provider will cooperate with Health Plan to collaborate on fulfilling any OHA requirements in the increased adoption of Health Information Exchange (HIE), Health Information Technology (HIT), and Electronic Health Record (EHR) technology.

5.2 Oregon Health Plan/OHA Capitation Administration Regulations

In the event of (a) new or changing requirements, rules, regulations or guidance related to applicable provider capitation payments made by Health Plan to Provider, 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 Provider, Health Plan may enact the following:

- A charge commensurate with any OHA recoupment, demand for repayment, charge, tax or fee, to be charged against the CCO Health Care Budget, and/or
- A renegotiation with Provider to revert all payment methodologies entailing Provider capitation, to a fee-for-service payment methodology.

Provider 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.

5.3 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 reimbursement agreed to in this 2020 Agreement, Health Plan will notify Provider of such inconsistency in writing, and both parties will enter into a renegotiation of 2020 reimbursement rates 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 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, PacificSource reserves the right to (a) deduct a pro-rata portion of such repayment from the Health Care Budget in Section 6, or (b) make direct investments to increase the MLR and offset such expenses with the settlement, upon communication with Provider and the CCO Health Council.

5.4 OHA MLR Reporting.

This reporting pertains specifically to the Exhibit L Financial Reporting Supplemental SE. Provider shall submit to Health Plan a report for each clinic for the cost time period of January 1 – June 30 by July 31, using a format accepted by the OHA. Provider shall submit to Health Plan a report for each clinic for the cost year January 1 – December 31 by February 28, using a format accepted by the OHA. Provider shall refer to the OHA CCO Contract Forms website at https://www.oregon.gov/oha/HSD/OHP/pages/cco-contract-forms.aspx for support. Any changes to reporting requirements set forth by the OHA will supersede the above requirements.

5.4 Community Health Improvement Plan, Transformation Plan and Health Council Activities.

Provider will collaborate with Health Plan, the CCO Health Council, 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. Provider will collaborate with PacificSource, the CCO Health Council, 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 CCO Health Council or any of its subcommittees, or for reporting to OHA, PacificSource may share Provider utilization, membership numbers, and additional performance data. Provider will collaborate with PacificSource and the CCO Health Council to meet Transformation And Quality Strategies requirements and participate in Transformation And Quality Strategy projects.

5.6 Value-Based Payment.

Provider agrees to participate in Health Plan's Value-Based Payment (VBP) program, consistent with OHA requirements in which an increasing portion of

provider payment conforms to the Learning and Action Network (LAN) category 2C or higher, which may entail the following elements.

- Payment based on any of the above methodologies
- Payment Withhold
- Surplus sharing
- Payment models to support care transformation and quality improvement in the following areas:

  Hospital Care
  Maternity Care
  Children's Care
  Behavioral Health Care
  Oral Health Care

In collaboration with Provider, PacificSource will share with Provider information pertaining to Health Information Technology (HIT) to support success in effective participation with the VBP program.

6.0 MISCELLANIOUS.

6.1 Defined Terms

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

6.2 Precedence

Any conflict or inconsistency shall be resolved by giving precedence to this Attachment first then the Participating Provider Agreement.

ATTACHMENT A-2
Polk County
Public Health
Effective 03/01/2025
Reimbursement Schedule

These rates shall apply to applicable PacificSource Community Solutions Networks and Products

SERVICE/PROCEDURE	MAXIMUM ALLOWABLE
Carve Outs:	
T1015 (U1)	$79.00 per unit
T1015 (U2)	$203.00 per unit
T1015 (U3)	$319.00 per unit
All Medical Services: Services as defined in the OHP Medical-Dental Fee Schedule	100% of OHP Allowable [1, 2]
All Behavioral Health Services: Services as defined in the OHP Behavioral Health Fee Schedule	100% of OHP Allowable [1, 2]
Laboratory: Services listed in the OHP Medical-Dental Fee Schedule	100% of OHP Allowable [1, 2]
Anesthesia: Service or supply with ASA Value	100% of OHP Allowable [2, 3]
Durable Medical Equipment, Prosthetics, Orthotics and Supplies: Services listed in the OHP Medical-Dental Fee Schedule	100% of OHP Allowable [1, 2]
Injectables, Vaccines, Immunizations: Services listed in the OHP Medical-Dental Fee Schedule	100% of Billed Charges
Services and procedures without an established unit value listed above: PacificSource Health Plans may establish such unit values for purposes of its Maximum Allowable rate determination.	PacificSource Community Solutions Default Fee Allowance [4]

Note: Payment will be based upon the lesser of the billed amount or PacificSource negotiated rates in effect at the time the service or supplies are rendered or provided as specified above.
1. PacificSource will reimburse based on the rates published as of the date of adjudication.
2. Updates to the schedules noted above shall be updated in accordance with OHP.
3. 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.
4. PacificSource utilizes industry standard publications and rate methods to supplement codes not established by the above noted methodologies.

ATTACHMENT A

Polk County
Effective 03/01/2025
Reimbursement Schedule

These rates shall apply to applicable Healthier Oregon Program and OHP Bridge Networks and Products.

SERVICE/PROCEDURE	MAXIMUM ALLOWABLE
All Medical Services: Services as defined in the OHP Medical-Dental Fee Schedule	100% of OHP Allowable [1, 2]
All Behavioral Health Services: Services as defined in the OHP Behavioral Health Fee Schedule	100% of OHP Allowable [1, 2]
Anesthesia: Service or supply with ASA Value	100% of OHP Allowable [2, 3]
Services and procedures without an established unit value listed above: PacificSource Health Plans may establish such unit values for purposes of its Maximum Allowable rate determination.	PacificSource Community Solutions Default Fee Allowance [4]

Note: Payment will be based upon the lesser of the billed amount or PacificSource negotiated rates in effect at the time the service or supplies are rendered or provided as specified above.
1. PacificSource will reimburse based on the rates published as of the date of adjudication.
2. Updates to the schedules noted above shall be updated in accordance with OHP.
3. 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.
4. PacificSource utilizes industry standard publications and rate methods to supplement codes not established by the above noted methodologies.

ATTACHMENT B
Polk County
03/01/2025
Credentialing

1.0 In the event that Health Plan is responsible for the credentialing of physicians and/or practitioners, the following information will be necessary to satisfy Health Plan credentialing or validation requirements:

1.1 Completed application for each physician and/or practitioner to include:

(a) Physician or practitioner name

(b) Practice name

(c) Specialty

(d) Physical Address

(e) Billing Address

(f) Tax Identification Number

(g) DEA Number (if applicable)

(h) NPI Number

(i) Phone (Appointment/Billing)

(j) Fax Number

(k) Clinical privileges at primary admitting facility (if applicable)

(l) Current valid license (if applicable)

(m) Current valid DEA certificate (if applicable)

(n) Education/training, as applicable to the provider type

(o) Board Certification (if applicable)

(p) Current adequate professional liability coverage

(q) History of liability claims

(r) Work history

(s) Evidence of completion of background check (if applicable)

1.2 Signed, dated PacificSource authorization for information release

1.3 Signed, dated statements attesting to:

(a) Ability to perform the essential functions of the position, with or without accommodations

(b) Absence of present illegal drug use

(c) Any history of loss of license and/or felony convictions

(d) Any history of loss or limitation of privileges

(e) The correctness/completeness of the application

1.4 Copies of the following must accompany the application, as applicable:

(a) Current valid license (if applicable)

(b) Valid DEA Certificate (if applicable)

(c) Current professional liability face sheet

2.0 In the event Health Plan credentialing duties are delegated to Provider; those delegated credentialing requirements will be specified in a separate Delegated Credentialing Agreement between Health Plan and Provider.

ATTACHMENT C

Polk County

03/01/2025

Scope of Work and Special Provisions

The following are required duties of Provider as detailed in the CCO Contract and Oregon Administrative Rules:

1.0 Provider's employees and subcontractors are required to participate in training as outlined in the OHA CCO Contract. Provider may attest to training they have provided to their employees and/or subcontractors by submitting information to Health Plan and/or participate in training provided by Health Plan. Training shall include, but not be limited to the following fundamental areas:

1.1. Cultural Responsiveness;

1.2. Implicit Bias;

1.3. Language access (including use of plain language and Health Care Language Interpreters);

1.4. Use of CLAS Standards in the provision of services;

1.5. Adverse Childhood Experiences/trauma informed practices that are culturally responsive;

1.6. Uses of REAL+D data to advance Health Equity;

1.7. Universal access and accessibility in addition to compliance with ADA;

1.8. Foundations of Trauma Informed Care;

1.9. Health care integration;

1.10. Recovery principles; and

1.11. Motivational Interviewing.

2.0 Provider shall assure that all employed Traditional Health Workers have met the requirements for background checks for Traditional Health Workers, as described in OAR 410-180-0326. Provider shall submit encounter data, workforce assessments, capturing non-encounterable services, and required reporting metrics for all services provided by Traditional Health Workers to Health Plan. In addition, Provider shall:

2.1. Track and document Member interactions with THWs;

2.2. Collaborate in the integration of THWs into the delivery of services;

2.3. Assist in communications to Members about the benefits of THW services;

2.4. Assist in the implementation of THW Commission best practices;

2.5. Assist in measuring baseline utilization and performance;

2.6. Coordinate with the OHA office of Equity and Inclusion to implement best practices;

2.7. Submit claims and encounter data for THW services in the clinic setting, non-clinic setting, and community-based settings; and

2.8. Collect data using the reporting template provided by OHA, including: Member satisfaction ratio of THWs to Members, number of THWs employed, requests by Members for THW services, number of engagements by THWs that are part of the Member's care team, demographics of THWs and CCO membership, and other data for each of the THW provider types including doulas, community health workers, peer support specialists, peer wellness specialists, and patient health navigators.

3.0 Provider shall cooperate on OHA-required workforce reporting requirements, metrics, coordination of care and care transition requirements, and other OHA requirements.

4.0 Provider shall screen all pregnant women for behavioral health needs at least once during pregnancy, at least once during the post-partum period, and shall develop a follow-up and/or referral plan as indicated by screening results.

5.0 Provider shall screen Members for adequate in home family supports (e.g., housing adequacy, nutrition/food, diaper needs, transportation needs, safety needs and home visiting).

6.0 Provider shall screen for all Members and provide prevention, early detection, brief intervention and referral(s) to Substance Use Disorders treatment who are in any of the following circumstances:

6.1. At an initial contact or during a routine physical exam;

6.2. At an initial prenatal exam;

6.3. When the Member shows evidence of Substance Use Disorders or abuse (as noted
in the OHA approved screening tools); and/or

6.4. When the Member over-utilizes Covered Services.

7.0 Primary care providers shall periodically conduct a socio-emotional screening for all children from birth to age five (5), and have a process to address concerns found by the screening.

8.0 Substance Use Disorder Providers shall provide available community resources information and referral to community services which may include without limitation child care, elder care, housing, transportation, employment, vocational training, educational services, mental health services, financial services, and legal services.

9.0 Behavioral Health Providers shall:

9.1. Use a trauma informed framework to develop individual service and support plans for Members to assess for Adverse Childhood Experiences, trauma, and resiliency in a culturally responsive manner, and

9.2. Report all data required by OHA using the OHA-specified data system(s).

9.3. Engage in the integration of behavioral health and physical health services.

10.0 Provider shall report accurate practitioner information for Health Plan's provider directory, and Provider shall report their total Member capacity consistent with OHA requirements, and Health Plan's policy and procedures.

11.0 Provider shall comply with the electronic health record adoption requirements of OHA, and Provider shall provide access to health information exchange technology for Provider's practitioners. Provider will provide to PacificSource any information about electronic

health record adoption and health information exchange access, consistent with OHA requirements and obligations of Health Plan.

ATTACHMENT D

Polk County

03/01/2025

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.

ADDENDUM

Polk County

03/01/2025

Youth Fidelity Wraparound

RECITALS

A. Wraparound is an intensive care coordination process for youth with emotional and behavioral disorders who are involved in multiple systems. These systems include, but are not limited to, mental health, addictions, child welfare, intellectual or developmental disabilities, juvenile justice, and education. Wraparound is a team-based, strengths-based process that organizes a youth-and-family-driven system of services and supports. Services and supports are individualized for a youth and family to achieve family and youth identified goals.

B. Provider is committed to participating in supporting the continuum of care that integrates health services by means of implementing a System of Care approach that includes models such as Wraparound for children with behavioral health disorders.

C. Provider serves as a Wraparound Provider or supports multiple Wraparound Providers, and Provider specializes in providing Wraparound supports to eligible Members in accordance with OAR 309-019-0162 & 309-019-0163. Provider delivers Wraparound supports pursuant to Fidelity Wraparound requirements, as required by OAR 309-019-0162 & 309-019-0163 and Exhibit M of the CCO Contract.

D. Provider is including this Addendum for the express purpose of supporting Wraparound services.

1. WRAPAROUND WORK.

Health Plan retains Provider to create, support, and manage the services for its Members in the Service Area as described and in accordance with this Section 1 (the "Wraparound Work"). Provider agrees to render all Wraparound Work in accordance with the terms and conditions of the Agreement and this Attachment, applicable state and federal law, applicable government regulations and guidance, and in conformity with appropriate and accepted standards of care for those services. Nothing herein is intended to create, and shall not create, any exclusive arrangement between Health Plan and Provider. This Agreement shall not restrict either Party from acquiring similar, equal or like goods or services from other entities or sources. The Parties acknowledge that there may be changes in OHA guidance or interpretation in the future that impact this Agreement. The Parties agree to work together to adjust and incorporate such OHA guidance and interpretations into this Agreement and/or into the work performed hereunder, as well as any new requirements from an amendment to the CCO Contract or as otherwise required by OHA. Provider shall perform Wraparound Work, as described in greater detail below:

1.1 Wraparound Services. Provider shall administer Wraparound care coordination services to Fidelity, consistent with the obligations set forth in OAR 309-019-0163 and Exhibit M of the CCO Contract. In particular, Provider shall:

- Ensure certified providers administer the Child and Adolescent Needs and Strengths Assessment ("CANS") Oregon to members, consistent with the requirements set forth in Exhibit M of the CCO Contract, including input of CANS data into state data system. All staff administering the CANS must be certified by the Praed Foundation;
- Ensure its providers and staff have attended the Division-approved foundational Wraparound training within 90 days of the hire date, applicable to the role in the Wraparound care team.
- Ensure its providers and staff are trained in integration and foundations of Trauma Informed Care, recovery principles, motivational interviewing, assessing for Adverse Childhood Experiences, and rendering services in a Culturally and Linguistically Appropriate manner.
- Complete required documents for each enrolled youth and their family pursuant to the Fidelity model.
- Input member information into state's Fidelity and Monitoring System, WrapStat, or other Division-required data monitoring system, including: Medicaid ID numbers, Wraparound enrollments, discharges, and member demographic information.
- Distribute WFI-EZs according to the evaluation cycles identified in WrapStat, ensuring all youth and members of their Wraparound team who are a part of the evaluation cycle are provided the opportunity to complete a WFI-EZ. WFI-EZs can be collected electronically through WrapStat or in hard copy format, with all paper copies required to be submitted to Health Plan for entry into WrapStat.
- Complete TOMs during evaluation cycles identified in WrapStat.

1.2 Clients Served. Provider shall be reimbursed for the number of Wraparound clients served each month. Provider will be responsible for invoicing PacificSource on a monthly basis to indicate youth enrolled in Wraparound program.

1.3 PacificSource's Wraparound Policies. Provider agrees to comply with Health Plan's Wraparound policies and procedures, including those policies and procedures described in Exhibit M of the CCO Contract. Provider also agrees to provide feedback not less than annually in order to support Health Plan in improving its policies and procedures to meet the needs of the local community.

1.4 Wraparound Staff. Provider will ensure the implementation of Fidelity Wraparound by hiring and training the following staff required in Exhibit M to deliver Wraparound Work:

- Wraparound Care Coordinator;
- Wraparound Supervisor;
- Wraparound Coach;

- Youth Peer Delivered Service Provider;
- Family Peer Delivered Service Provider; and
- Peer Delivered Service Provider Supervisor.

1.5 Workforce. On not less than a quarterly basis, Provider agrees to share with Health

Plan a summary of its workforce, including whether any of its employed or contracted workforce are certified or grandfathered as traditional health workers, as well as their corresponding scope of practice using a THW reporting template supplied by Health Plan. This information is required by the OHA, and allows the Health Plan to develop targeted strategies to meet member health needs. After Provider produces this analysis, the Parties agree to meet and review the analysis to discuss barriers and opportunities.

1.6 Assistance in Meeting OHA Obligations. Provider agrees to cooperate with and assist PacificSource in fulfilling PacificSource's obligations to the OHA with regard to services performed under this Agreement.

1.7 Behavioral Health Report. Provider agrees to collaborate with Health Plan to complete reporting to the OHA, including the Behavioral Health Report that Health Plan must submit to the OHA on an annual basis.

1.8 Wraparound Collaboration. Provider agrees to work collaboratively with Health Plan staff, as reasonably requested. Provider also agrees to participate in technical assistance offered by Health Plan, including training in trauma-informed care principles.

1.9 Participation in System of Care Governance. Provider agrees to participate in System of Care work groups, including the Practice Level Workgroup, to support a comprehensive, person-centered, individualized, and integrated community-based array of child and youth behavioral health services using System of Care principles.

1.10 Participation in Community Governance. Provider agrees to participate in the local Community Health Assessment and Community Health Improvement Plan, as may be requested by Health Plan or the [insert Health Council], from time to time. In addition, Provider agrees to participate in the Community Advisory Council to share valuable perspectives with the community and the [Health Council].

1.11 Caseloads. Provider shall track the ratio of care coordinators, family support specialists, and youth support specialists to families served. Provider shall maintain adequate staffing in order to ensure that at no time the ratio of providers to families served exceeds 1:15. If at any time the ratio exceeds 1:15, Provider shall immediately notify Health Plan so that Health Plan may take appropriate next steps pursuant to Health Plan's policies and procedures.

1.12 Data Collection and Reporting. In order to support Provider and Health Plan's joint efforts to serve Members and in service of the OHA's requirements to collect data about the delivery of Wraparound services, Provider agrees to provide reporting to Health Plan that includes the following:

- Wraparound Annual Utilization Report (annually)
- Number of youth served (quarterly)
- Ratio of employed or contracted staff to total number of youth served (quarterly)
- Number of requests for Wraparound services and number enrolled in Wraparound, including explanations for those not enrolled (quarterly)
- Number of youth discharged from Wraparound (quarterly)
- Race/Ethnicity and Language of eligible members enrolled in and discharged from Wraparound (quarterly)

1.13 Reporting Penalties. Provider agrees to supply the reporting deliverables listed in Section 1.12. Provider agrees to indemnify and hold Health Plan harmless against any and all fines, fees, and/or assessments assessed by the Oregon Health Authority as a result of Provider's failure to timely meet the reporting deliverables identified in this Agreement.

1.14 Encounter Data. Provider agrees to submit claims for all Wraparound services provided by Wraparound staff, as identified in Section 1.4. All Wraparound services (excluding CANS assessments billed using H2000) shall be submitted and include the member's diagnosis or diagnoses, Procedure Code H2021, Community-based Wraparound Services, per 15 minutes, and the number of units per service (e.g., a 45 minute encounter would require claim submission of H2021 for 3 units). These claims are for encounter reporting purposes only and will not be reimbursed, per payment agreement in Attachment A.

1.15 Workforce Training. Provider shall ensure that all staff receive training as required in the Contract including, but not limited to, Cultural Responsiveness, Implicit Bias, CLAS Standards, Trauma Informed Care, and uses of data to advance health equity. Provider and provider staff may access trainings offered by the PacificSource Training Program. For all other training, Provider shall have mechanisms in place that enable reporting to Health Plan, at Health Plan's reasonable request, details of training activities, annual training plans, training subjects, content outlines, objectives, target audiences, delivery system, evaluations, training hours, training attendance, and trainer qualifications. At a minimum, Provider shall provide Health Plan with an Annual Training and Education Report so that Health Plan may compile such information into Health Plan's report to the OHA.

2. PAYMENT.

Provider shall be paid for providing the Wraparound Work pursuant to Attachment A of the Agreement.

3. TERM AND TERMINATION.

This Addendum shall be in full force and effect for the Term of the Agreement, unless earlier terminated as provided herein. Either Party may terminate this Addendum, without impacting the Agreement, with the other Party's written consent, which shall not be unreasonably withheld.

4. DATA USE.

The Parties recognize and agree that it may be necessary to share certain data with each other that was not anticipated to give this Addendum its full force and effect. The Parties agree that they will meet and determine the exact data to provide, in accordance with the

terms of this Addendum, as it becomes necessary. The additional specifications for that data may be added as an amendment, at any time, to this Addendum as mutually agreed to by the Parties. The Parties acknowledge that the CCO Contract requires significant reporting to OHA, including documentation establishing compliance with OAR 309-019-0163, and agree to work together to ensure the proper completion and filing of such reports so that Health Plan may fulfill its obligations under the CCO Contract. Provider acknowledges that OHA will post many of the reports on its website. Where redaction of certain information is allowed, the Parties will coordinate on the identification of those redactions, although Health Plan will have the right to make the final redactions based on its sole discretion.