POLK COUNTY BOARD OF COMMISSIONERS

DATE: April 9, 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) A public meeting of the Budget Committee for Polk County will be held in the Main Conference Room, Polk County Courthouse, 9:00 a.m., on Tuesday, April 22, 2025. The purpose of the meeting is to discuss the budget for fiscal year July 1, 2025 to June 30, 2026 and to receive the budget message and document. The public meeting will continue on Wednesday, April 23, 2025. Additional time is reserved for public comment at 10:30 a.m. Wednesday, April 23, 2025. A copy of the budget document may be inspected or obtained on or after April 18, 2025 at the Board of Commissioners' Office, Polk County Courthouse, during regular business hours. This is a public meeting where deliberation of the Budget Committee will take place. Any person may appear at the meeting and discuss the proposed budget with the Budget Committee. Please advise the Board of Commissioners (503-623-9237) at least 24 hours in advance if you need special accommodations to attend or participate in the meeting virtually.

3. COMMENTS (for items not on this agenda and limited to 3 minutes. We encourage all community members to engage with public comments to the Board of Commissioners. However, out of respect for our audience and a general sense of decorum please refrain from vulgar, threatening or inappropriate language.)
4. APPROVAL OF AGENDA
5. APPROVAL OF THE MINUTES FROM April 2, 2025
6. APPROVAL OF CONSENT CALENDAR
7. LENGTH OF SERVICE AWARDS – Matt Hawkins
   - Todd Whitaker, 15 Years of Service
   - Sidney Mulder, 10 Years of Service
8. PUBLIC HEARING – JURISDICTIONAL TRANSFER TO THE CITY OF INDEPENDENCE – Darren Blackwell
9. RECLASSIFICATION OF AN EMPLOYEE – Matt Hawkins

CONSENT CALENDAR

a) Polk County Contract No. 25-34, PacificSource Community Solutions (Rosana Warren, Health Services)

b) Polk County Resolution No. 25-07, In the matter of Community Dispute Resolution (Greg Hansen, Administrative Officer)

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

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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 April 2, 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 and Commissioner Gordon were present.

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.

3. COMMENTS

None.

4. APPROVAL OF AGENDA

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

ALL SAID YES.
MOTION PASSED BY UNANIMOUS VOTE OF THE BOARD.

5. APPROVAL OF MINUTES OF March 26, 2025

MOTION: COMMISSIONER GORDON MOVED, COMMISSIONER MORDHORST SECONDED, TO APPROVE THE MINUTES OF March 26, 2025.

ALL SAID YES.
MOTION PASSED BY UNANIMOUS VOTE OF THE BOARD.

6. CHILD ABUSE PREVENTION PROCLAMATION

Abby Warren, FCO, stated that they were here today to declare the month of April as Child Abuse Prevention Month, which is something that Polk County has been doing for several years now. Mrs. Warren provided background information on this Proclamation and explained why it was so important to her and the FCO staff. Mrs. Warren stated that she was thankful to be here today with some of their community partners like Liberty House. Commissioner Pope invited a member of Liberty House, Max Goodfriend, to come up and speak about what they are doing in the community to help children and families in need. Mr. Goodfriend introduced himself and talked about some of the main issues that they are seeing with children right now and how they are trying to help those children. Mr. Goodfriend stated that they are going into the middle schools and have a program called “My Worth” and he explained what that entails, why he is proud of that curriculum and the types of discussions they are having with the youth. Next, Mr. Goodfriend talked about the other online safety training programs that they offer and stated that they are available in both English or Spanish and they are free. Mr. Goodfriend talked about a

program called, “Let’s Talk,” that is for adults and it helps parents talk to their children about difficult topics. Mrs. Warren wanted to say how lucky they are to have Max and to be partnering with Liberty House. Commissioner Gordon thanked them for a great presentation and stated that he plans to stay in touch with them. Commissioner Mordhorst also said thank you for the excellent presentation.

MOTION: COMMISSIONER MORDHORST MOVED, COMMISSIONER GORDON SECONDED, TO APPROVE AND SIGN PROCLAMATION NO. 25-01 INTO THE RECORD.

ALL SAID YES.
MOTION PASSED BY UNANIMOUS VOTE OF THE BOARD.

Commissioner Pope read aloud Polk County Proclamation No. 25-01 into the record.

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

N/A

There no need for an executive session and Commissioner Pope adjourned the meeting at 9:19 a.m.

POLK COUNTY BOARD OF COMMISSIONERS

Craig Pope, Chair

Jeremy Gordon, Commissioner

Lyle Mordhorst, Commissioner

Minutes: Nicole Pineda
Approved: April 9, 2025

Polk County Public Works

County Surveyors Office

820 SW Ash Street ♦ Dallas OR 97338 ♦ 503-623-1887

MEMORANDUM

TO: Board of Commissioners

FROM: Darren Blackwell, County Surveyor

DATE: April 3, 2025

SUBJECT: Surrendering Jurisdiction of Various Roadways to the City of Independence

Wednesday, April 9, 2025 –Public Hearing/Agenda Item

RECOMMENDATION;
That the Board accept and sign the attached Order surrendering portions of various roadways to the City of Independence.

ISSUE:
Shall the Board of Commissioners accept this surrender of jurisdiction?

DISCUSSION:
In October of 2024 the City of Independence annexed portions of 13th Street, E Street, Gun Club Rd, Talmadge Rd, and Stryker Rd (see attached). The City has now requested by Resolution No. 25-1624 Polk County surrender jurisdiction of these various roadways to the City.

FISCAL IMPACT:
Some staff time and Recording fees.
Reduced road maintenance costs.

Enclosures;
City of Independence Ordinance No. 1619 (Ordinance Declaring Roadways Annexed into the City).

BEFORE THE CITY COUNCIL OF THE CITY OF INDEPENDENCE
COUNTY OF POLK, STATE OF OREGON

A Resolution Requesting Polk County	]
To Surrender Jurisdiction To City	]
Over Certain County Roadways	]

RESOLUTION NO. 25-1624

WHEREAS, the City Council for the City of Independence deems it necessary, expedient, and in the best interest of the City to seek surrender of jurisdiction over portions of certain County roads from the Polk County Board of Commissioners identified as follows:

All those portions of 13th Street, E Street, Gun Club Road, Talmadge Road, and Stryker Road as described in the exhibits contained in the City of Independence Ordinance No 1619 dated October 22, 2024.

WHEREAS, ORS 373.270(6)(a) authorizes the City to initiate the surrender of the County's jurisdiction over all or a portion of county roads which lie with City limits; and

WHEREAS, the Board of Commissioners of Polk County, Oregon has authority under ORS 373.270(6)(b) to surrender jurisdiction over requested portions of County roads by order, without further action by the City; and

WHEREAS, upon the County surrendering jurisdiction over the above-described portions of 13th Street, E Street, Gun Club Road, Talmadge Road, and Stryker Road by order, that County jurisdiction shall cease and the City shall have full and absolute jurisdiction over the requested portions of road for all purposes of repair, construction, improvement, and the levying and collection of assessment; **Now, Therefore**

THE CITY COUNCIL OF THE CITY OF INDEPENDENCE HEREBY RESOLVES AS FOLLOWS:

Section 1. **Transfer of Jurisdiction.** The City Council hereby requests that Polk County, acting by and through its Board of Commissioners under the provisions of ORS 373.270(6), surrender jurisdiction to the City of those portions of 13th Street, E Street, Gun Club Road, Talmadge Road, and Stryker Road described above and in the attached Exhibit A, which is incorporated herein by this reference.

Section 2. City of Independence personnel are hereby directed to provide Polk County all information and documentation needed to support this Resolution request to the Board of County Commissioners.

Section 3. Effective Date. This Resolution shall take effect immediately upon adoption by the City Council.

ADOPTED by the City Council of the City of Independence, Oregon this 28th day of January, 2025.

CITY OF INDEPENDENCE, OREGON

By Kate Schwarzler
Kate Schwarzler, Mayor

ATTEST:

By Myra Russell
Myra Russell, City Recorder

BEFORE THE CITY COUNCIL OF THE CITY OF INDEPENDENCE
STATE OF OREGON, COUNTY OF POLK

An Ordinance Declaring Roadways Annexed to the City of Independence, and Stating an Effective Date	]]]	Council Bill #2024-08

ORDINANCE NO. 1619

WHEREAS, pursuant to ORS 222.111(2) and the City's Development Code Sections 11.002.D and 12.005, the City of Independence ("City") initiated the annexation of portions of various roadways identified on Exhibit A ("Subject Properties") on September 10, 2024; and

WHEREAS, the Subject Properties are existing County roads, located within the City of Independence's Urban Growth Boundary; and

WHEREAS, the Subject Properties are either within or contiguous to the City of Independence City boundaries, as required by ORS 222.111(1); and

WHEREAS, on September 17, 2024, the city provided notice of the annexation hearing to the Department of Land Conservation and Development; and

WHEREAS, notice of the annexation hearing was published in the local newspaper, twice, on October 2, 2024 and October 9, 2024; and

WHEREAS, on October 22, 2024 the City Council conducted a properly noticed public hearing that met the requirements of ORS 222.120(3), at which time interested parties and the general public had an opportunity to be heard, and reviewed the record and recommendations of staff; and

WHEREAS, at the close of the public hearing, the City Council determined that the evidence and argument presented in the public hearing and on the record showed that the requested annexation of the Subject Properties comply with all applicable provisions of the City of Independence Development Code and state law, as explained in the findings contained in the Staff Report attached as Exhibit B;

NOW, THEREFORE, THE CITY OF INDEPENDENCE DOES ORDAIN AS FOLLOWS:

Section 1. Annexation. The Subject Properties described in Exhibit A, attached hereto and incorporated herein by this reference, are hereby declared annexed to the City of Independence.

Section 2. Findings. The City of Independence hereby adopts the above recitals and the findings contained in the Staff Report, attached hereto as Exhibit B and incorporated herein by this reference, as the basis for this decision to annex the Subject Properties.

Section 3. Recordation. The City Recorder is hereby authorized and directed to: (1) make and submit to the Secretary of the State of Oregon, the assessor of Polk County, the County Clerk of Polk County, and the Department of Revenue, State of Oregon, a certified copy of this Ordinance; (2) provide notice of the final adoption of this annexation Ordinance to the subject parcel property owners, anyone who participated in the public hearing, and anyone who requested notice of this decision; and (3) provide notice to public utilities as directed by ORS 222.005.

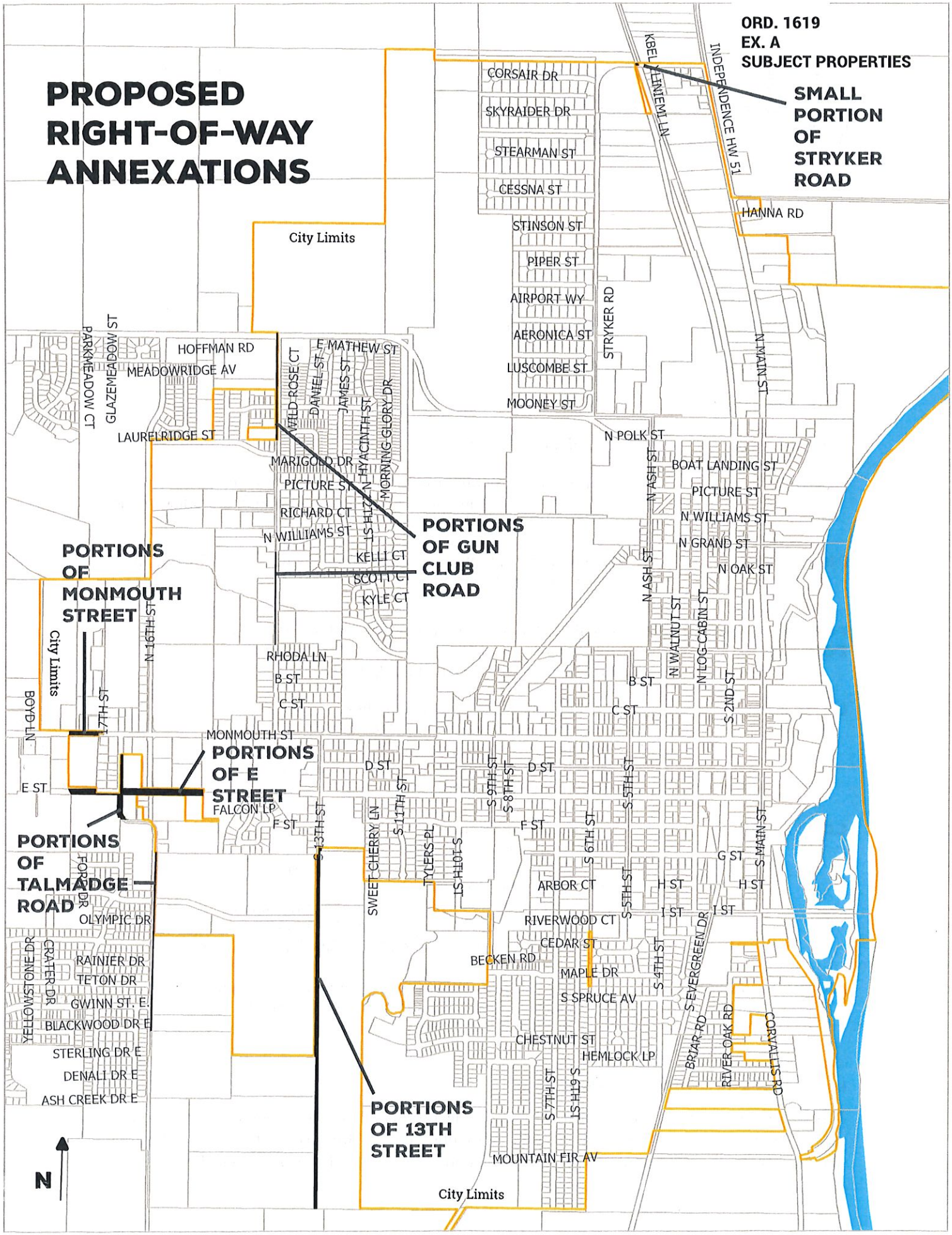
Section 4. The Ordinance shall take effect 30 days after second reading and final passage, and the annexation will be effective on the same date, unless a later date is required pursuant to ORS 222.040.

READ for the first time: 10/22/2024
READ for the second time: 10/22/2024
APPROVED by Council: 10/22/2024
SIGNED by the Mayor: 10/22/2024

JOHN McARDLE, MAYOR

ATTEST:

Karin Johnson, MMC, City Recorder


PROPOSED RIGHT-OF-WAY ANNEXATIONS
ORD. 1619
EX. A
SUBJECT PROPERTIES
SMALL PORTION OF STRYKER ROAD
PORTIONS OF GUN CLUB ROAD
PORTIONS OF MONMOUTH STREET
PORTIONS OF E STREET
PORTIONS OF TALMADGE ROAD
PORTIONS OF 13TH STREET
City Limits
CORSAIR DR
SKYRAIDER DR
STEARMAN ST
CESSNA ST
STINSON ST
PIPER ST
AIRPORT WY
AERONICA ST
LUSCOMBE ST
MOONEY ST
KBELL LINIEMI LN
INDEPENDENCE HWY 51
HANNA RD
STRYKER RD
N MAIN ST
N POLK ST
BOAT LANDING ST
PICTURE ST
N WILLIAMS ST
N GRAND ST
N OAK ST
N ASH ST
N WALNUT ST
N LOG CABIN ST
S 2ND ST
HOFFMAN RD
MEADOWRIDGE AV
PARKMEADOW CT
GLAZEMEADOW ST
LAUREL RIDGE ST
WILD ROSE CT
DANIEL ST
E MATHEW ST
JAMES ST
HYACINTH ST
MORNING GLORY DR
MARIGOLD DR
PICTURE ST
RICHARD CT
N WILLIAMS ST
N 4TH ST
KELLI CT
SCOTT CT
KYLE CT
RHODA LN
B ST
C ST
D ST
E ST
F ST
G ST
H ST
I ST
N 16TH ST
N 17TH ST
BOYD LN
MONMOUTH ST
FALCON LP
S 13TH ST
S 11TH ST
S 10TH ST
S 9TH ST
S 8TH ST
S 7TH ST
S 6TH ST
S 5TH ST
S MAIN ST
SWEET CHERRY LN
TYLERS PL
ARBOR CT
RIVERWOOD CT
CEDAR ST
BECKEN RD
MAPLE DR
S SPRUCE AV
CHESTNUT ST
HEMLOCK LP
MOUNTAIN FIR AV
S 4TH ST
S EVERGREEN DR
BRIAR RD
RIVER OAK RD
CORVALLIS RD
FORD DR
OLYMPIC DR
YELLOWSTONE DR
CRATER DR
RAINIER DR
TETON DR
GWINN ST. E.
BLACKWOOD DR E
STERLING DR E
DENALI DR E
ASH CREEK DR E
N

INDEPENDENCE
Oregon's Story Begins Here

TYPE III ANNEXATION AND ZONE CHANGE (FILE NO. AX | 2024-03)
STAFF REPORT

MEETING DATE:	October 22, 2024
RECOMMENDATION:	**APPROVE**
FILE NUMBER:	AX	2024-03
APPLICANT:	City of Independence
REQUEST:	Annex Certain Rights-of-Way into the City of Independence. No Comprehensive Plan Future Land Use Designation or Zoning would be Established for the Rights-of-Way
PROPERTY:	Portions of Monmouth Street, E Street, Talmadge Road, Gun Club Road, 13th Street, and Stryker Road
FUTURE LAND USE/ ZONING:	Existing: County – Suburban Residential (SR) or Exclusive Farm Use (EFU) Zone Proposed: City – No zoning proposed
CRITERIA:	Independence Comprehensive Plan Independence Development Code (IDC) -Subchapter 11: Administration -Subchapter 12: Zone Changes and Plan Amendments -Subchapter 14: Annexation
CONTENTS:	I. Background and Process II. Agency and Public Comments III. Recommended Conditions of Approval IV. Potential Council Actions V. Staff Findings – Oregon State Planning Goals VI. Staff Findings – Independence Comprehensive Plan VII. Staff Findings – Independence Development Code
ATTACHMENTS:	A. Rights of Way Proposed to be Annexed (1 page) B. Legals of Proposed Annexations (17 pages) C. Comment from Smith (1 page)

I. BACKGROUND AND PROCESS

This application seeks to annex several rights of way into the City of Independence. These rights-of-way include portions of Monmouth Street, Talmadge Road, E Street, Gun Club Road, 13th Street and Stryker Road. Attachment A provides a depiction of the rights-of-way that would be annexed.

The annexation is intended to start a process to conduct a jurisdictional transfer of county roads to city jurisdiction. The transfer is sought:

- To ensure that the construction or reconstruction of roads is completed to city public works, transportation master plan, and development code standards when development happens along those roadways.
- To streamline the process for property owners to make improvements to roads fronting their properties (many of the roadways currently have portions in both the city and the county and any improvement projects require the approval of both the jurisdictions).
- To allow the city to control speed limits and set specific speed safety zones, such zones for parks, businesses, and schools.

All told, the change is intended to ensure the consistent management and improvement of rights-of-way in the Urban Growth Area. If the annexation is approved, the city would have jurisdiction over all roadways within the Independence Urban Growth Boundary except for OR-51, and portions of Hoffman Road, Corvallis Road and 6th Street. The annexation of the remaining segments of Hoffman Road, Corvallis Road and 6th Street is anticipated to occur in early 2025. ODOT will retain jurisdiction over the entirety of OR-51.

II. AGENCY AND PUBLIC COMMENTS

To provide notice of the annexation, the city sent out notice to individuals within 250 feet of each of the roadway segments on October 3, 2024. One public comment was provided regarding the application as of the date of this staff report (see Attachment C).

III. POTENTIAL COUNCIL ACTIONS

Based on the findings below, the Council may:

- Move to approve AX | 2024-03 with findings and conditions, as presented within this report, and adopt a Council Bill to approve of the changes.
- Move to approve AX | 2024-03 with modifications and direct staff to prepare a Council Bill to approve of the changes.
- Request additional information.
- Deny the proposal.

A suggested motion to approve the application as presented is: "I move to approve File No. AX-2024-03, the annexation of certain rights-of-way into the City of Independence, adopting findings, conditions and staff recommendations as provided in the Staff Report."

Should the application be approved, the council may then consider an ordinance to approve the annexation and to apply a blank city future land use/zoning designation:

> *"I move to read the proposed Ordinance, Council Bill #2024-08 in full as the text is contained in the Council packet, for the first time."*
>
> If passed, the Recorder will read the title of the proposed ordinance to the council. If the motion is approved unanimously, the Council may have a second reading:
>
> *"I move to read the proposed Ordinance, Council Bill #2024-08 for the second time by title only."*
>
> If passed, the Recorder will read the title of the proposed ordinance to the council, and a motion to adopt is in order:

"I move to adopt the proposed Ordinance, Council Bill #2024-08."

Following that, the Recorder will declare that the proposed ordinance has passed and assign the ordinance number.

IV. STAFF FINDINGS - INDEPENDENCE COMPREHENSIVE PLAN

Annexations and changes to the Independence Comprehensive Plan and Zoning Map are required to meet the Oregon State Planning Goals. Among these goals include provisions related to Citizen Involvement (Goal 1), Land Use Planning (Goal 2), Housing (Goal 10), Public Facilities (Goal 11), Transportation (Goal 12) and Urbanization (Goal 14), which together are implemented through measures such as the Independence Comprehensive Plan and Development Code. Combined these goals seek to

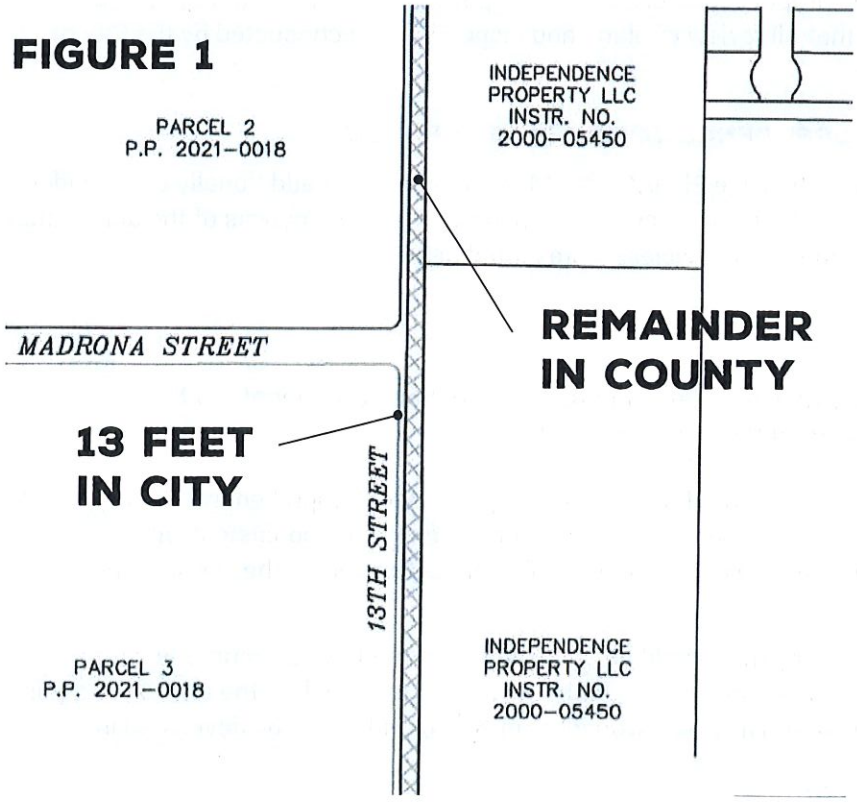
- "Provide and encourage a safe, convenient and economic transportation system." (see Goal 12)
- "Provide for an orderly and efficient transition from rural to urban land use." (see Goal 14)
- "Accommodate urban population and urban employment inside urban growth boundaries." (see Goal 14)
- Assure that citizens are involved in the planning process. (see Goal 1)

This annexation has been pursued with these provisions in mind.

The annexation of the roadways would allow the City of Independence to control the bulk of the roads in the Urban Growth Boundary, which would streamline the review of projects and ensure that development meets city standards as future development occurs (ensuring an orderly and efficient transition of the Urban Growth Boundary from rural to urban land use). The proposal would also limit the possibility that both jurisdictions would have to conduct separate reviews of roadway projects. For example, with the existing city boundary, roads such as Talmadge Road, 13th Street, and Gun Club Road have small strips of land that are within the city limits, and larger strips that are within the unincorporated Urban Growth Boundary (see Figure 1). Given the configuration, applicants would be required to get approval from both the City of Independence and Polk County for improvements to the roads.

The proposed annexation would make the city solely responsible for the facilities.

FIGURE 1



Source: Portion of Annexation Exhibit for 13th Street

Given these items, the proposal would help promote the orderly development and maintenance of the roads in the Independence Urban Growth Boundary and would be consistent with the Oregon State Planning Goals.

V. STAFF FINDINGS – INTERGOVERNMENTAL AGREEMENT BETWEEN POLK COUNTY AND THE CITY OF INDEPENDENCE

Annexation of property is additionally required to be consistent with the intergovernmental agreement between Polk County and the City of Independence for the management of the Independence unincorporated Urban Growth Boundary. Per the agreement, the city and county agreed that "the type and form of development within urbanizable areas is to be guided by the municipality's adopted land use and growth management plans" (see Policy 5) and that Polk County would "retain responsibility for land use decisions and actions affecting the urbanizable area until such time as annexation to the city occurs" (see Policy 6). The inherent tension between these policies is a key reason to annex the facilities.

Under the agreement, the County makes decisions about the design of roads based on city standards as long as the roadways remain in County jurisdiction. This framework requires the County to use and interpret the city development standards and runs the risk that key standards (such as the depth of rock on which the road is built, the width of a sidewalk, or the placement of a pipe) are overlooked as part of the review. If a standard is missed, the improved roadway will not conform to city standards and the city will be forced to either annex a substandard road, pay to improve the road (to meet city standards), or elect to not annex the facility because of the cost to improve the street.

To limit the possibility of errors, the proposed annexation would put the roadways completely under the jurisdiction of the city and ensure that all review of plans and inspections be conducted by the City of Independence.

VI. STAFF FINDINGS - INDEPENDENCE COMPREHENSIVE PLAN

Proposals for annexation and Comprehensive Plan/Zoning Map changes must additionally be considered following the goals and policies of the Independence Comprehensive Plan. An analysis of the annexation and redesignation/rezone, considering these policies, is presented below.

Land Use

GOAL: To encourage efficient land use, maintain land use designations appropriate to the character of Independence and meet future land use needs.

Staff Response: The Land Use Element of the City of Independence Comprehensive Plan seeks to encourage efficient land use, and to zone annexed land consistent with Comprehensive Plan designations. This annexation meets these goals and policies.

The rights-of-way that would be annexed would not have a Comprehensive Plan or zoning designation (in keeping with the historic approach of the city to the zoning of rights-of-way). The roads would be un-zoned and would be developed in

accordance with the road standards in the Transportation System Plan and the Public Works Design Standards.

This approach would achieve this goal.

Urbanization

GOAL: To provide for an orderly and efficient transition from rural to urban land.

Staff Response:

Goals and policies related to Urbanization in the City of Independence seek to promote the orderly and efficient transition of properties from rural to urban land use. Key policies to implement this goal seek to:

- Promote coordination with Polk County to manage the Urban Growth Boundary.
- Annex land in a manner that is consistent with the Comprehensive Plan and any Concept Plans adopted for the area.

This proposal effectively addresses these policies.

The proposal is sought specifically to allow the city to guide the design and construction of the roads as new development occurs. This approach would ensure the orderly and efficient transition of land from rural to urban land use.

This goal and policies will be achieved.

Transportation

...

Staff Response:

The goals of the Transportation System Plan seek to

- "Develop and maintain a transportation system that is consistent with the community vision of a vibrant, historic, riverfront, full-service community." (see Goal 1)
- "Support the development and implementation of transportation solutions that are future focused." (see Goal 5)
- "Maintain the financial stability of the city." (see Goal 6)

This annexation would support these intents.

The proposed annexation would ensure that the city has control of roadways that are envisioned to implement the community vision within the Transportation System Plan and would assure that the roads are able to be built in accord with city standards. Additionally, the right-of-way annexation would anticipate future development, and be fiscally responsible, ensuring that the city would manage the review and construction of any improvements to the roadways. The city jurisdiction over the roads would help ensure that roads were constructed in a manner that met city standards and would minimize the confusion (and cost) that may result from another jurisdiction reviewing an Independence development project.

Given these facts, the proposed annexation would support the community vision, be future focused, and be fiscally responsible. These goals would be achieved.

V. STAFF FINDINGS - INDEPENDENCE DEVELOPMENT CODE

The proposed annexation and rezone request is considered a Type III action under the Independence Development Code Section 11.002(C). The action requires a quasi-judicial review by the City Council, without a review by the Independence Planning Commission. Standards for the decision are presented in Subchapter 11 (Administrative Provisions), Subchapter 12 (Zone Changes and Plan Amendments) and Subchapter 14 (Annexations). These standards are presented below.

Subchapter 11: Administrative Provisions

Staff Response: The application to annex the roadways is considered a Type III action in the Independence Development Code. As such, the application requires a Public Hearing and decision by the Independence City Council.

The annexation request is subject to ORS 222.170. At the meeting of September 10, 2024, the City Council elected to dispense with submitting the question to the electors of the city and directed staff to provide notice for a public hearing on the proposal. Following that decision, the city published notice of the hearing twice in the Polk County Itemizer-Observer, posted the notice in three locations in the city (the Civic Center, library and Heritage Museum), and sent the notice to property owners within 250 feet of the project site. Given these items, the standards in Subchapter 11 are met.

One comment has been submitted as a result of the notice provided as part of the application. This comment is attached to this staff report (see Attachment C). Staff will be prepared to address the issues raised within the comment letter at the hearing on October 22.

Subchapter 12: Zone Changes and Plan Amendments

12.005 Initiation of a Zone Change or Plan Amendment

A zone change or plan amendment may be initiated in any one of the following ways:

A. The City Council may initiate such action by resolution. The resolution shall be forwarded to the City Manager, who shall set a date for a public hearing before the Planning Commission and give notice of such hearing as provided in this ordinance.

B. The Planning Commission may initiate such action by resolution. The resolution shall be forwarded to the City Manager, who shall set a date for a public hearing before the Planning Commission and give notice of such hearing as provided in this ordinance.

C. A property owner may initiate such action by petition for the owner's own property.

Staff Response: The City of Independence has submitted a request for the annexation. The property to be annexed would not have a future land use or zoning designation. This standard is met.

12.010 Zone Change and Plan Amendment by Petition

Any property owner may initiate a zone change or plan amendment for the property that he or she owns by submitting to the City Recorder a petition bearing the following:

...

Staff Response: The applicant has submitted the necessary paperwork for a future land use/rezone proposal. The application would annex portions of Monmouth Street, Talmadge Road, E Street, Gun Club Road, 13th Street and Stryker Road. As part of the annexation, no zone or Future Land Use designation would be applied to the areas. This standard is achieved.

12.020 Action by the City Council

Upon receipt of a recommendation from the Planning Commission for any zone change or plan amendment, the City Council shall hold a public hearing. The City Council shall base its decision upon the findings, conclusions and recommendations reached by the Planning Commission unless, by a preponderance of the evidence, it finds facts and reaches conclusions different from those reached by the Planning Commission. All zone changes or plan amendments shall be based on written findings. Any zone change or plan amendment shall be by ordinance. Any denial of a request for a zone change or plan amendment shall be by resolution.

Staff Response: No Planning Commission review is required for the annexation and redesignation/rezone request per IDC Section 11.002(C). Any City Council decision on the application will be supported by written findings and the adoption of the change will be supported by an adopting ordinance.

12.025 Standards for Zone Changes

No zone change shall be approved by the Planning Commission or enacted by the City Council unless it conforms to the Comprehensive Plan, including the Transportation System Plan, and at least one of the following standards is met:

A. The zoning on the land for which the zone change is initiated is erroneous and the zone change would correct the error;

B. Conditions in the neighborhood surrounding the land for which the zone change is initiated have changed to such a degree that the zoning is no longer appropriate and the zone change would conform to the new conditions of the neighborhood;

C. There is a public need for land use of the kind for which the zone change is initiated and that public need can best be met by the zone change.

Staff Response: The annexation of the roadways is intended to be a future focused, fiscally responsible approach that will ensure that roads in the Urban Growth Area are constructed in accordance with city standards.

The annexation would help:

- To ensure that the construction or reconstruction of roads is completed to city public works, transportation master plan, and development code standards when development happens along the roadways.
- To streamline the process for property owners to make improvements to roads fronting their properties (many of the roadways currently have portions in both the city and the county and any improvement projects would require the approval of both jurisdictions).
- To allow the city to control speed limits and set specific speed safety zones, such as zones for parks, businesses, and schools.

Given these items, the annexation of the land would address both Criteria A and C above. The revised zoning would address a zoning error (that would occur if the land was annexed) and the rezoning of the land would address a clear public need. Given these items, this standard is met.

Subchapter 14: Annexation

14.030 Master Plan Requirement for Southwest Independence Concept Plan Area

...

Staff Response: The annexation subchapter in the Independence Development Code (Subchapter 14) deals with annexations in the Southwest Independence Concept Area and establishes a master plan requirement for the properties. No requirements are specified for roads, except that they generally follow the framework articulated within the plan. The roads proposed to be annexed in the Southwest Area would conform with the street network identified in the plan.

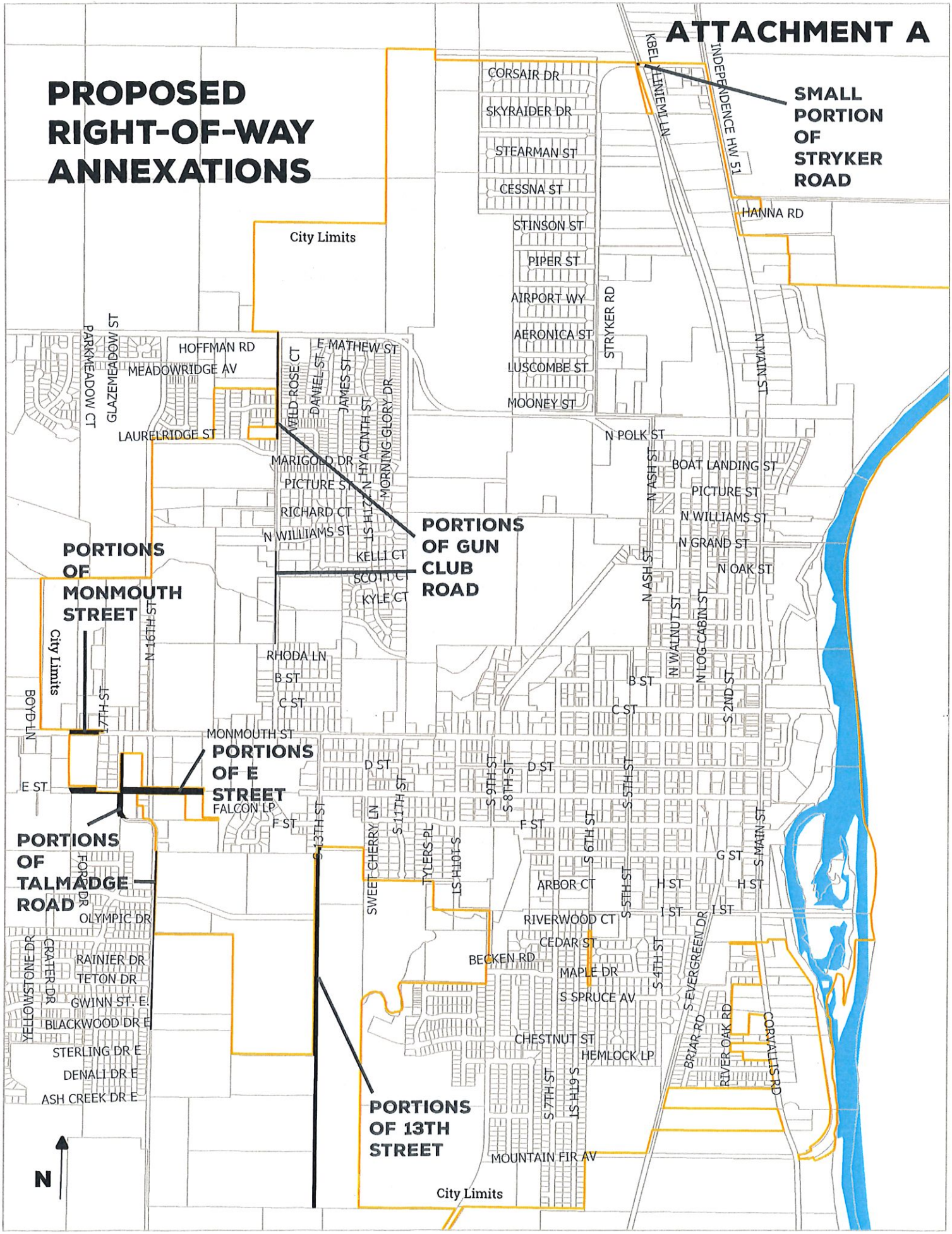

ATTACHMENT A
PROPOSED RIGHT-OF-WAY ANNEXATIONS
SMALL PORTION OF STRYKER ROAD
PORTIONS OF GUN CLUB ROAD
PORTIONS OF MONMOUTH STREET
PORTIONS OF E STREET
PORTIONS OF TALMADGE ROAD
PORTIONS OF 13TH STREET
City Limits
CORSAIR DR
SKYRAIDER DR
STEARMAN ST
CESSNA ST
STINSON ST
PIPER ST
AIRPORT WY
AERONICA ST
LUSCOMBE ST
MOONEY ST
KBELLINGHAM LN
INDEPENDENCE HWY 51
HANNA RD
STRYKER RD
N MAIN ST
N POLK ST
BOAT LANDING ST
PICTURE ST
N WILLIAMS ST
N GRAND ST
N OAK ST
N ASH ST
N WALNUT ST
N LOG CABIN ST
S 2ND ST
B ST
C ST
D ST
F ST
G ST
H ST
I ST
S MAIN ST
S 5TH ST
S 6TH ST
S 7TH ST
S 8TH ST
S 9TH ST
S 11TH ST
S 13TH ST
S 16TH ST
S 17TH ST
S 19TH ST
S 4TH ST
S EVERGREEN DR
CORVALLIS RD
RIVER OAK RD
BRIAR RD
HEMLOCK LP
CHESTNUT ST
MAPLE DR
S SPRUCE AV
CEDAR ST
RIVERWOOD CT
ARBOR CT
BECKEN RD
MOUNTAIN FIR AV
SWEET CHERRY LN
TYLERS PL
FALCON LP
MONMOUTH ST
E ST
BOYD LN
N 16TH ST
RHODA LN
RICHARD CT
KELLI CT
SCOTT CT
KYLE CT
MARIGOLD DR
PICTURE ST
WILD ROSE CT
DANIEL ST
JAMES ST
E MATHEW ST
HYACINTH ST
MORNING GLORY DR
LAURELRIDGE ST
HOFFMAN RD
MEADOWRIDGE AV
PARKMEADOW CT
GLAZEMEADOW ST
FORD DR
OLYMPIC DR
RAINIER DR
TETON DR
GWINN ST. E.
BLACKWOOD DR E
STERLING DR E
DENALI DR E
ASH CREEK DR E
YELLOWSTONE DR
CRATER DR
N

EXHIBIT A

A unit of land situated in the southwest one-quarter of Section 20, Township 8 South, Range 4 West, of the Willamette Meridian, Polk County, Oregon, being a portion of North Gun Club lying southerly of Williams Avenue and northerly of Rhoda Lane, and more particularly described as follows:

Beginning at the southeast corner of Parcel 2 of Partition Plat 1995-0023, Polk County Plat Records, being coincident with the west line of said North Gun Club Road and the north line of the Urban Growth Boundary;

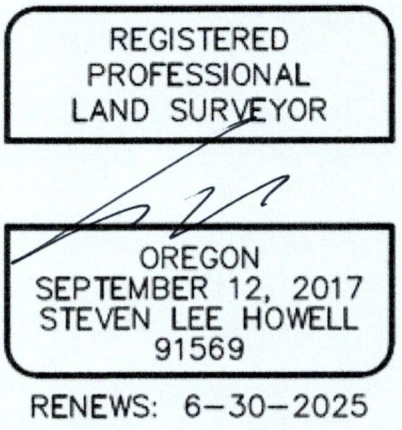
thence, going easterly along the north line of said Urban Growth Boundary approximately 20 feet to an angle point therein;

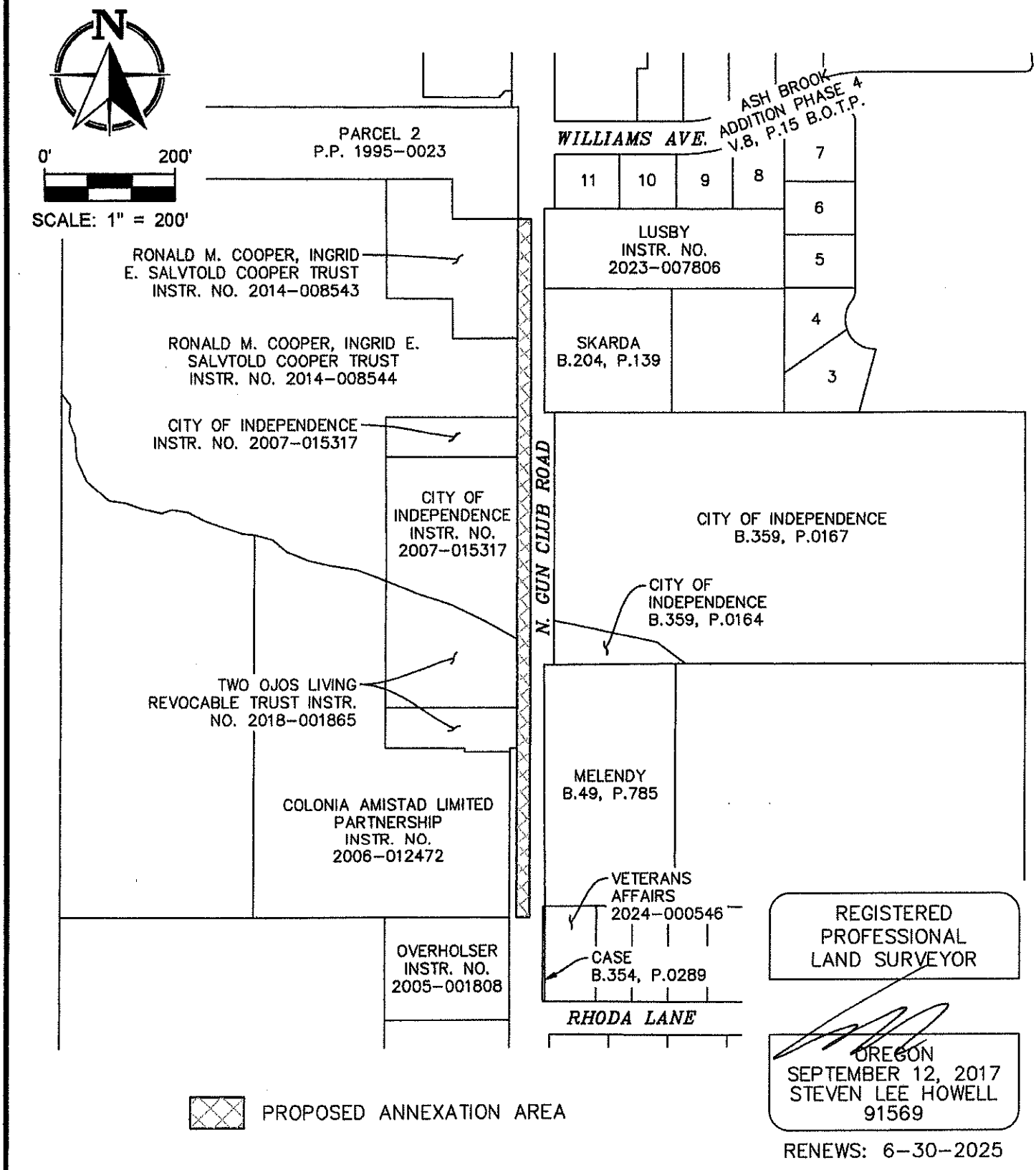
thence, going southerly along said Urban Growth Boundary approximately 1,060 feet to an angle point therein;

thence, going westerly along said Urban Growth Boundary approximately 20 feet to an angle point therein;

thence, going northerly along said Urban Growth Boundary approximately 258 feet to the southeast corner of that property conveyed to Two Ojos Living Revocable Trust by Instrument Number 2018-001865, Polk County Deed Records, being coincident with the west line of said North Gun Club Road;

thence, continuing northerly along the west line of said North Gun Club Road approximately 801 feet to the Point of Beginning.





REGISTERED
PROFESSIONAL
LAND SURVEYOR

OREGON
SEPTEMBER 12, 2017
STEVEN LEE HOWELL
91569

RENEWS: 6-30-2025

EXHIBIT B

IN THE SW 1/4 OF SECTION 20,
TOWNSHIP 8 SOUTH, RANGE 4 WEST, W.M.
POLK COUNTY, OREGON

DATE: FEBRUARY 20, 2024

SURVEYED FOR: CITY OF INDEPENDENCE

FFN SURVEYING
7230 3rd Street SE #145, Turner, OR 97392
P: (503) 558-3330 E: info@ffnsurveying.com

JOB NO.
23-477

SHEET
1/1

EXHIBIT A

A unit of land situated in Section 29 and the north one-half of Section 32, Township 8 South, Range 4 West, of the Willamette Meridian, Polk County, Oregon, being a portion of 13th Street lying south of F Street, and more particularly described as follows:

Beginning at the northeast corner of Partition Plat 2021-0018, Polk County Plat Records, being coincident with the Urban Growth Boundary;

thence, going easterly along said Urban Growth Boundary approximately 8 feet to an angle point therein;

thence, going northerly along said Urban Growth Boundary approximately 42 feet to an angle point therein;

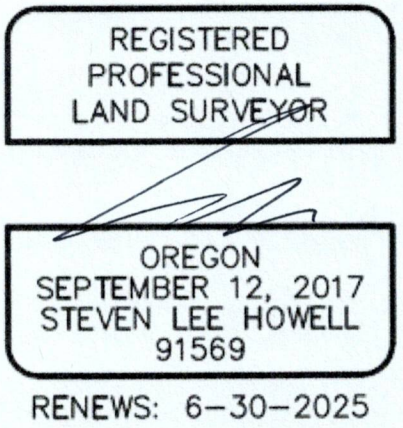
thence, going easterly along said Urban Growth Boundary approximately 20 feet to the northwest corner of that property conveyed to Independence Property LLC by Instrument Number 2000-05450, Polk County Deed Records, being coincident with the east line of said 13th Street;

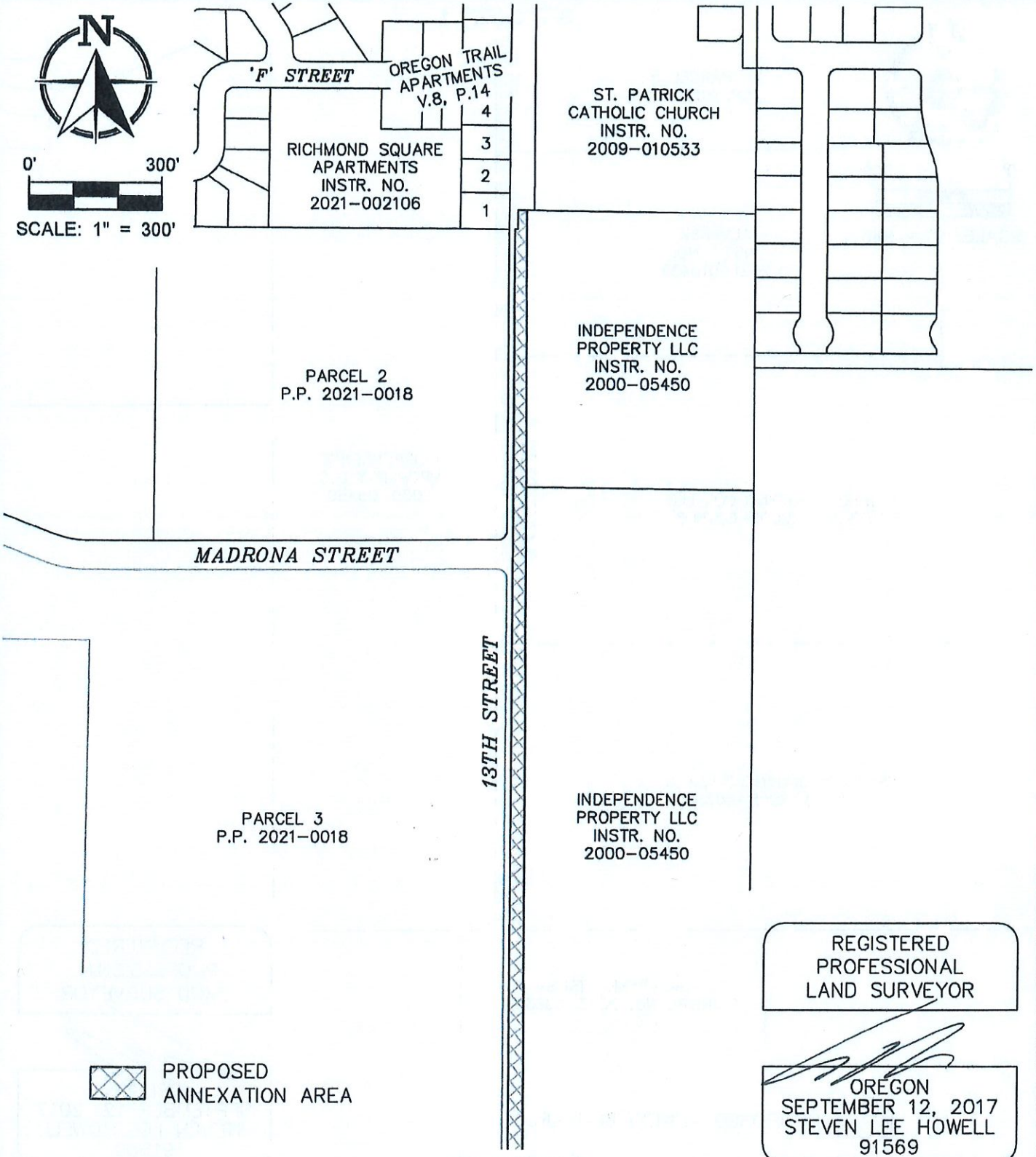
thence, going southerly along the east line of said 13th Street approximately 4,100 feet to the south line of said 13th Street, being coincident with the north line of that property conveyed to the Schwanke Trust by Instrument Number 2023-008342, Polk County Deed Records;

thence, going westerly along the south line of said 13th Street, being coincident with the north line of said Schwanke Trust property, approximately 40 feet to the west line of said 13th Street;

thence, going northerly along the west line of said 13th Street, approximately 1,745 feet to the southeast corner of said Partition Plat 2021-0018;

thence, continuing northerly, along the east line of said Partition Plat 2021-0018, approximately 2,314 feet to the Point of Beginning.





REGISTERED PROFESSIONAL LAND SURVEYOR

OREGON
SEPTEMBER 12, 2017
STEVEN LEE HOWELL
91569

RENEWS: 6-30-2025

EXHIBIT B

IN SECTION 29 & THE N. 1/2 OF SECTION 32, TOWNSHIP 8 SOUTH, RANGE 4 WEST, W.M. POLK COUNTY, OREGON

DATE: SEPTEMBER 18, 2024

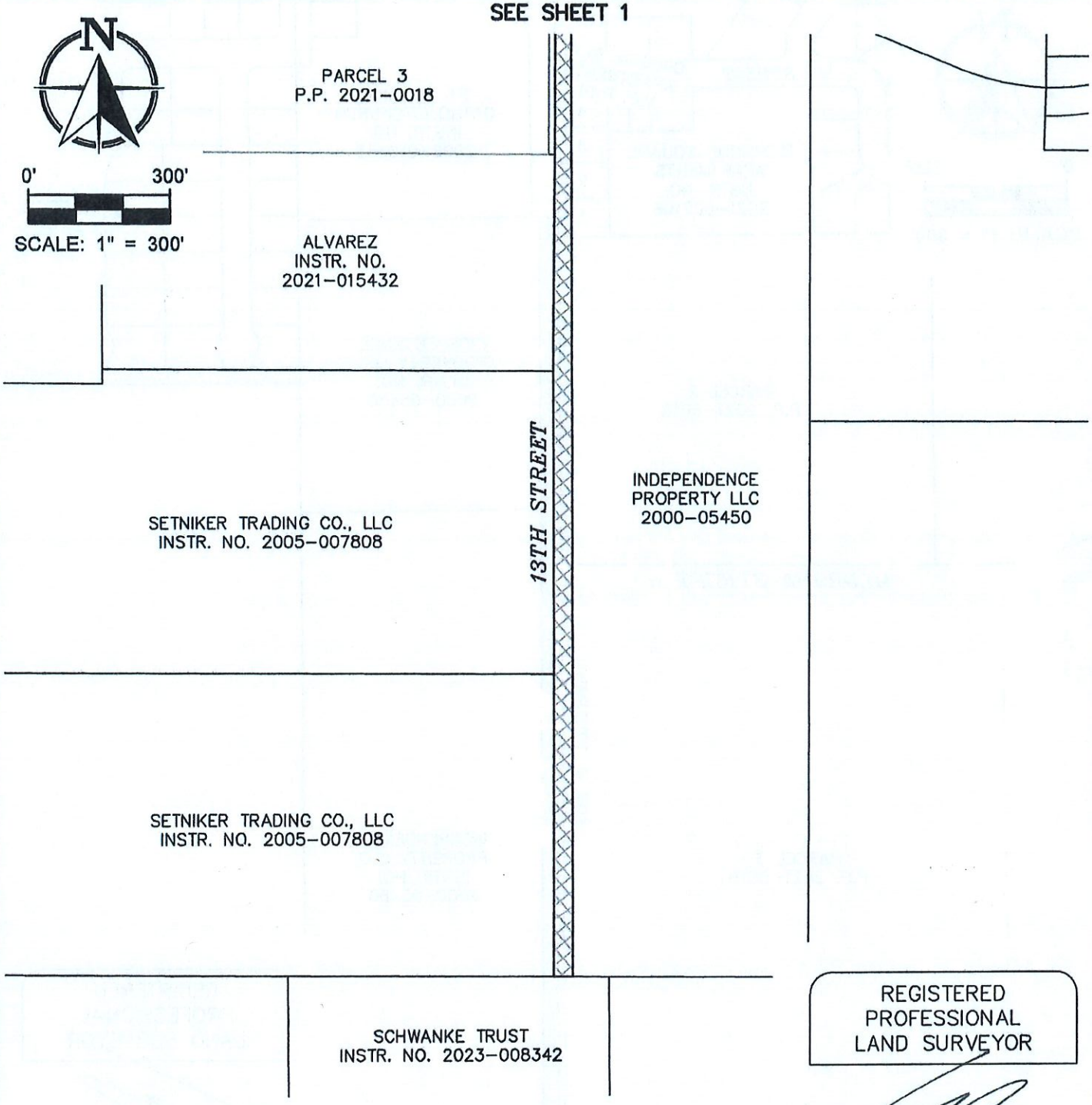
SURVEYED FOR: CITY OF INDEPENDENCE

FFN SURVEYING
7230 3rd Street SE #145, Turner, OR 97392
P: (503) 558-3330 E: info@ffnsurveying.com

JOB NO. 23-477

SHEET 1/2

SEE SHEET 1



REGISTERED
PROFESSIONAL
LAND SURVEYOR

OREGON
SEPTEMBER 12, 2017
STEVEN LEE HOWELL
91569

RENEWS: 6-30-2025

EXHIBIT B

IN SECTION 29 & THE N. 1/2 OF SECTION 32,
TOWNSHIP 8 SOUTH, RANGE 4 WEST, W.M.
POLK COUNTY, OREGON

DATE: SEPTEMBER 18, 2024

SURVEYED FOR: CITY OF INDEPENDENCE

FFN SURVEYING
7230 3rd Street SE #145, Turner, OR 97392
P: (503) 558-3330 E: info@ffnsurveying.com

JOB NO.
23-477

SHEET
2/2

EXHIBIT A

A unit of land situated in the west one-half of Section 29, Township 8 South, Range 4 West, of the Willamette Meridian, Polk County, Oregon, being a portion of Talmadge Road lying south of Monmouth Street, and more particularly described as follows:

Beginning on the northwest corner of that property conveyed to Hailwood by Instrument Number 2015-011359, Polk County Deed Records, being coincident with the east line of said Talmadge Road;

thence, going southerly along the east line of said Talmadge Road, approximately 830 feet to a point of tangency, being coincident with the south line of that property conveyed to Jacobs by Instrument Number 2015-004748, Polk County Deed Records, also being coincident with the Urban Growth Boundary;

thence, going westerly along the Urban Growth Boundary approximately 99 feet to the west line of said Talmadge Road;

thence, going northerly along the west line of said Talmadge Road approximately 311 feet to the south line of E Street;

thence, going easterly along the easterly extension of the south line of said E Street approximately 35 feet to the centerline of said Talmadge Road, being coincident with the Urban Growth Boundary;

thence, going northerly along said Urban Growth Boundary, being coincident with the centerline of said Talmadge Road, approximately 462 feet to an angle point in said Urban Growth Boundary;

thence, going easterly along said Urban Growth Boundary approximately 32 feet the Point of Beginning.

TOGETHER WITH, all that part Talmadge Road lying southerly of E Street, being further described as follows:

Beginning at the northwest corner of Partition Plat 2021-0018, Polk County Plat Records;

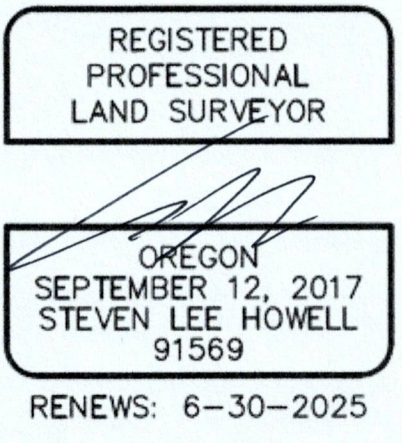
thence, going southerly, along west line of said Partition Plat 2021-0018, approximately 926 feet to the southwest corner thereof, being coincident with the east line of said Talmadge Road;

thence, continuing southerly along the east line of said Talmadge Road approximately 1,114 feet to the southwest corner of that property conveyed to Moss by Instrument Number 2022-002137, Polk County Deed Records;

thence, going westerly approximately 26 feet to the centerline of said Talmadge Road;

thence, going northerly along the centerline of said Talmadge Road approximately 2,040 feet to a point lying westerly of said Point of Beginning;

thence, going easterly approximately 20 feet to the Point of Beginning.



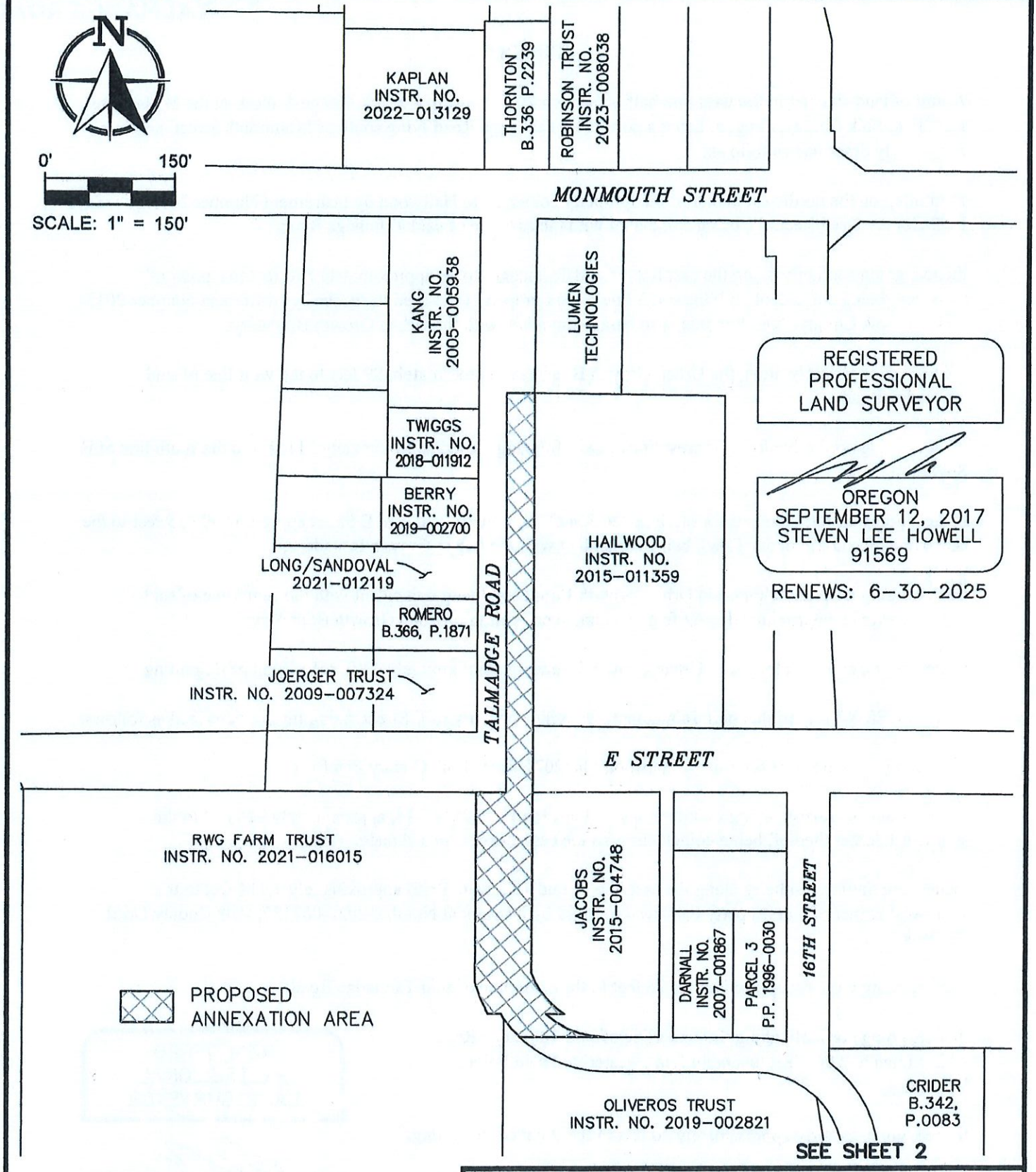


EXHIBIT B

IN THE WEST 1/2 OF SECTION 29,
TOWNSHIP 8 SOUTH, RANGE 4 WEST, W.M.
POLK COUNTY, OREGON

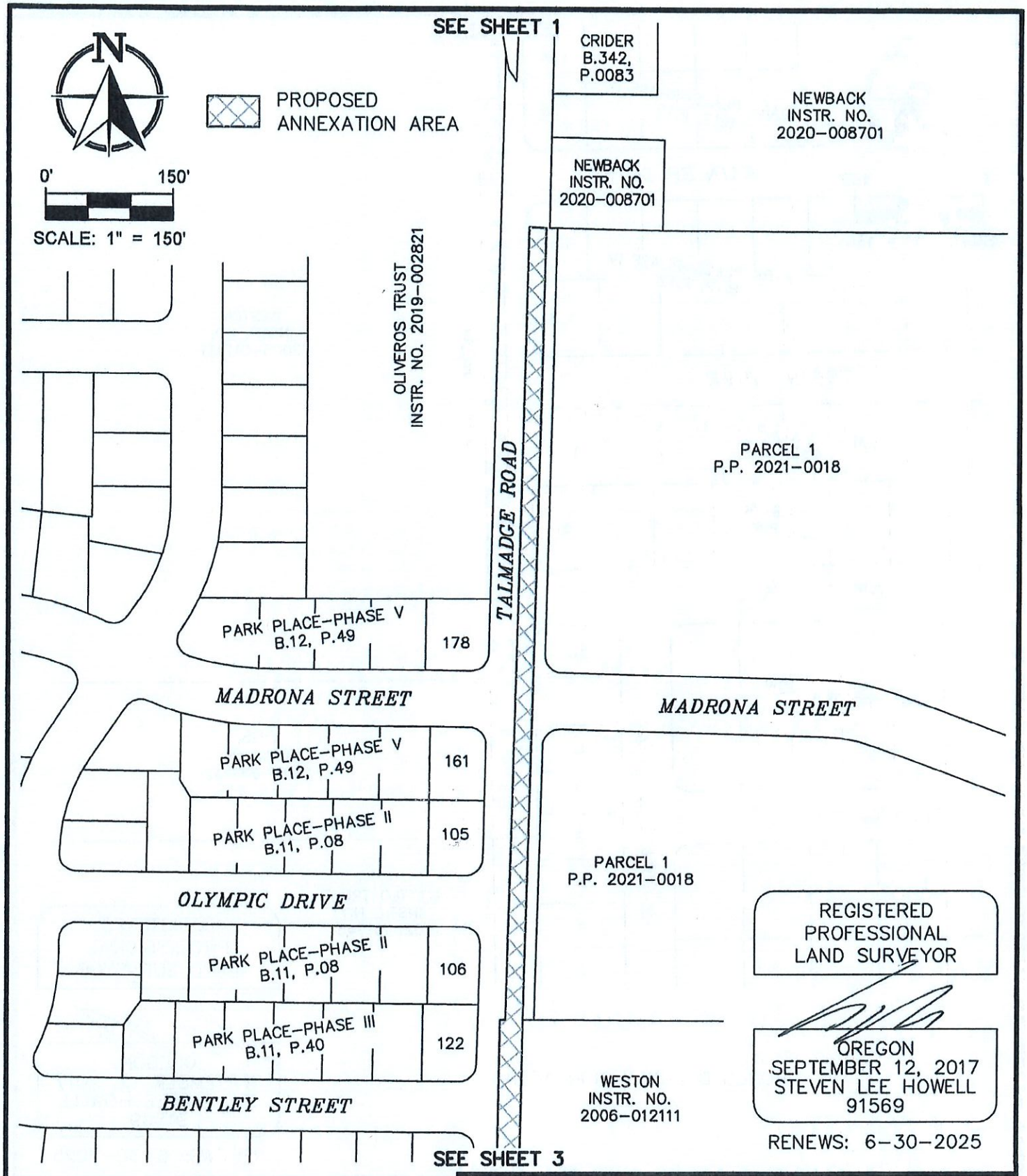
DATE: SEPTEMBER 18, 2024

SURVEYED FOR: CITY OF INDEPENDENCE

FFN SURVEYING
7230 3rd Street SE #145, Turner, OR 97392
P: (503) 558-3330 E: info@ffnsurveying.com

JOB NO. 23-477

SHEET 1/3



REGISTERED PROFESSIONAL LAND SURVEYOR

OREGON
SEPTEMBER 12, 2017
STEVEN LEE HOWELL
91569

RENEWS: 6-30-2025

EXHIBIT B

IN THE WEST 1/2 OF SECTION 29, TOWNSHIP 8 SOUTH, RANGE 4 WEST, W.M. POLK COUNTY, OREGON

DATE: SEPTEMBER 18, 2024

SURVEYED FOR: CITY OF INDEPENDENCE

FFN SURVEYING
7230 3rd Street SE #145, Turner, OR 97392
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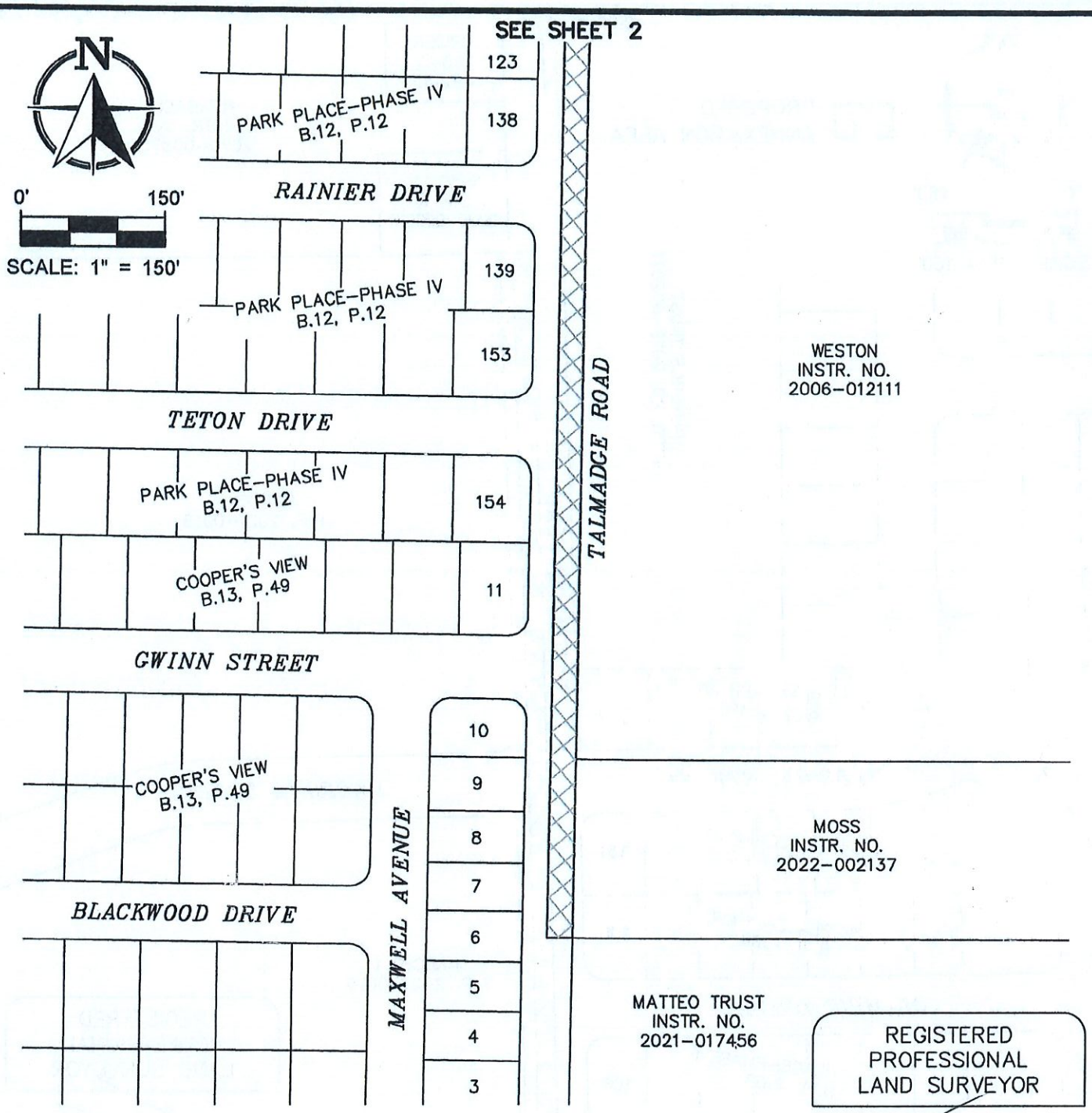
JOB NO. 23-477

SHEET 2/3



REGISTERED
PROFESSIONAL
LAND SURVEYOR

OREGON
SEPTEMBER 12, 2017
STEVEN LEE HOWELL
91569

RENEWS: 6–30–2025

EXHIBIT B

IN THE WEST 1/2 OF SECTION 29,
TOWNSHIP 8 SOUTH, RANGE 4 WEST, W.M.
POLK COUNTY, OREGON

DATE: SEPTEMBER 18, 2024

SURVEYED FOR: CITY OF INDEPENDENCE

FFN SURVEYING
7230 3rd Street SE #145, Turner, OR 97392
P: (503) 558-3330 E: info@ffnsurveying.com

JOB NO.
23–477

SHEET
3/3

EXHIBIT A

A unit of land situated in the northeast one-quarter of Section 30 and the northwest one-quarter of Section 29, Township 8 South, Range 4 West, of the Willamette Meridian, Polk County, Oregon, being a portion of E Street lying westerly of Talmadge Road, and more particularly described as follows:

Beginning on the north line of E Street, being coincident with the southwest corner of that property conveyed to Winco Foods, LLC, by Instrument Number 2004-004902, Polk County Deed Records;

thence, going easterly along the north line of said E Street approximately 317 feet to the southeast corner of said property, being coincident with the Urban Growth Boundary;

thence, going southerly along the Urban Growth Boundary approximately 70 feet to the south line of said E Street;

thence, going westerly along the south line of said E Street approximately 315 feet;

thence, going northerly approximately 63 feet to the Point of Beginning.

TOGETHER WITH, all that part of E Street lying easterly of Talmadge Road, being more particularly described as follows:

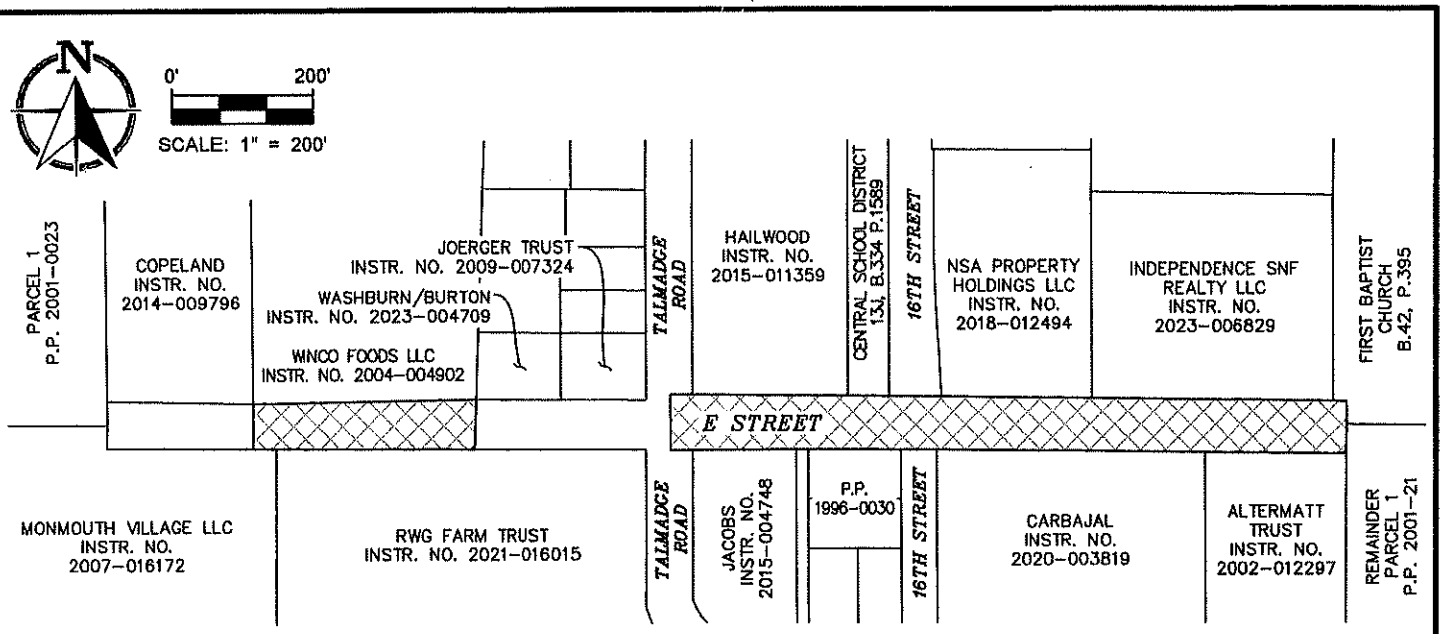
Beginning on the south line of E Street, being coincident with the northeast corner of that property conveyed to Altermatt Trust by Instrument Number 2002-012297, Polk County Deed Records;

thence, going westerly along the south line of said E Street, and the westerly extension thereof, approximately 956 feet to the centerline of Talmadge Road;

thence, going northerly along the centerline of said Talmadge Road approximately 77 feet to the westerly extension of the north line of said E Street;

thence, going easterly along said westerly extension, and continuing on the north line thereof, approximately 956 feet to the east line of said E Street;

thence, going southerly along the east line of said E Street approximately 73 feet to the Point of Beginning.



PROPOSED ANNEXATION AREA

REGISTERED
PROFESSIONAL
LAND SURVEYOR

OREGON
SEPTEMBER 12, 2017
STEVEN LEE HOWELL
91569

RENEWS: 6-30-2025

EXHIBIT B

IN THE NE 1/4 OF SECTION 30 & THE NW 1/4 OF SECTION 29
TOWNSHIP 8 SOUTH, RANGE 4 WEST, W.M.
POLK COUNTY, OREGON

DATE: SEPTEMBER 18, 2024

SURVEYED FOR: CITY OF INDEPENDENCE

FFN SURVEYING
7230 3rd Street SE #145, Turner, OR 97392
P: (503) 558-3330 E: info@ffnsurveying.com

JOB NO.
23-477

SHEET
1/1

EXHIBIT A

A unit of land situated in the west one-half of Section 20, Township 8 South, Range 4 West, of the Willamette Meridian, Polk County, Oregon, being a portion of North Gun Club lying southerly of Hoffman Road, and more particularly described as follows:

Beginning at the southeast corner of Parcel 2 of Partition Plat 1997-0058, Polk County Plat Records, being coincident with the west line of said North Gun Club Road;

thence, going northerly along the west line of said North Gun Club Road, being coincident with the east line of said Parcel 2, approximately 136 feet to the south line of QUAIL CROSSING, recorded in Volume 15, Page 26, Polk County Plat Records;

thence, going easterly, along the south line of said QUAIL CROSSING, approximately 11 feet to the southeast corner thereof;

thence, going northerly, along the east line of said QUAIL CROSSING, approximately 437 feet to the northeast corner thereof;

thence, going westerly, along the north line of said QUAIL CROSSING, approximately 11 feet to the northeast corner of Lot 34 of said QUAIL CROSSING, being coincident with the west line of said North Gun Glub Road;

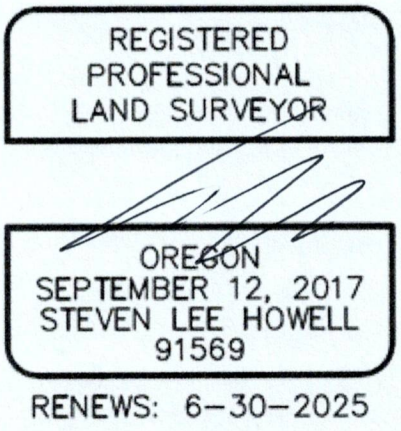
thence, going northerly, along said west line of North Gun Club Road, approximately 584 feet to the south line of said Hoffman Road;

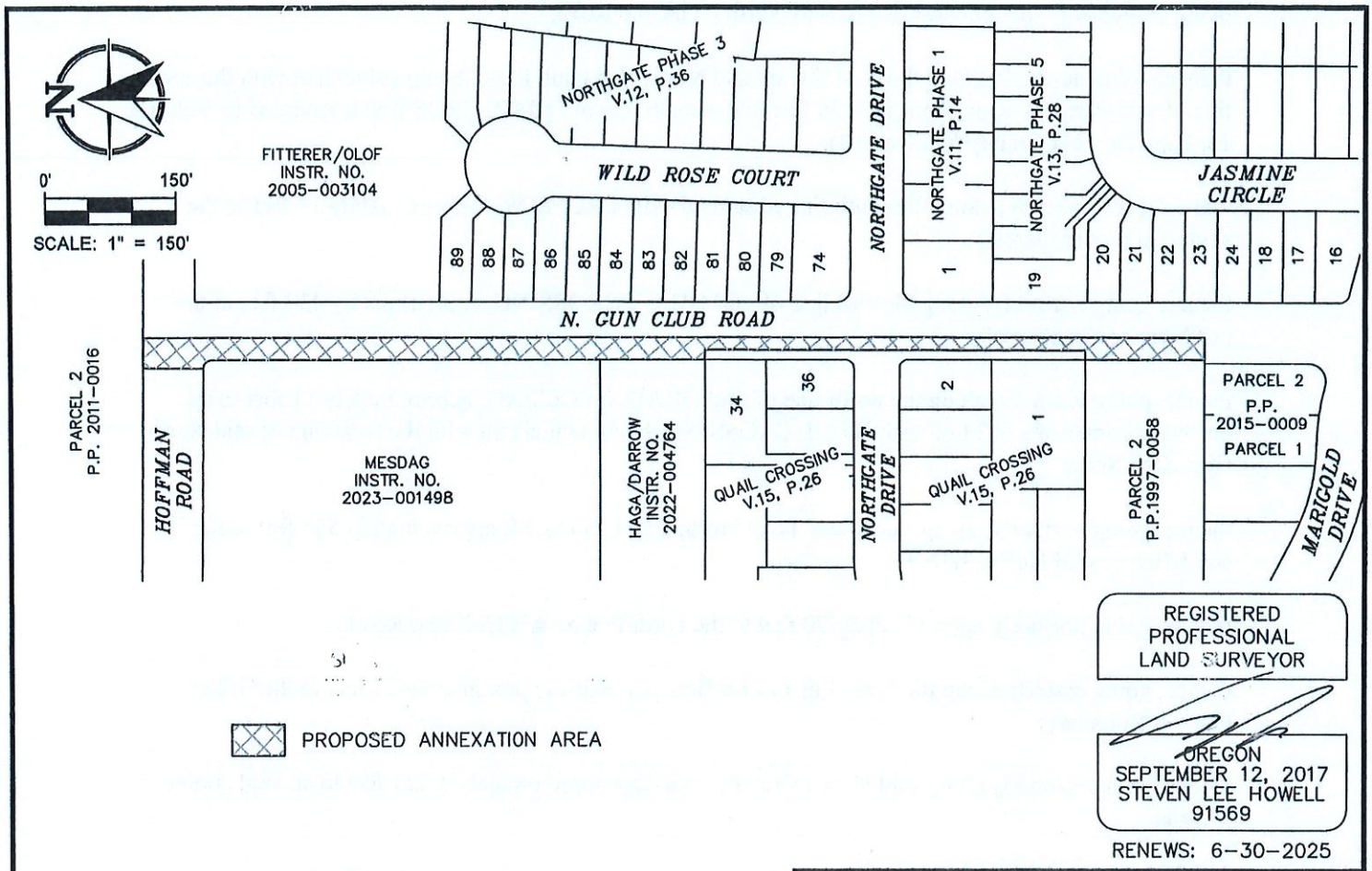
thence, going northerly approximately 70 feet to the north line of said Hoffman Road;

thence, going easterly along the north line of said Hoffman Road approximately 35 feet to the Urban Growth Boundary;

thence, going southerly along said Urban Growth Boundary approximately 1,223 feet to an angle point therein;

thence, going westerly along said Urban Growth Boundary approximately 25 feet to the Point of Beginning;





REGISTERED
PROFESSIONAL
LAND SURVEYOR

OREGON
SEPTEMBER 12, 2017
STEVEN LEE HOWELL
91569

RENEWS: 6-30-2025

EXHIBIT B

IN THE WEST 1/2 OF SECTION 20
TOWNSHIP 8 SOUTH, RANGE 4 WEST, W.M.
POLK COUNTY, OREGON
DATE: SEPTEMBER 18, 2024

SURVEYED FOR: CITY OF INDEPENDENCE

FFN SURVEYING
7230 3rd Street SE #145, Turner, OR 97392
P: (503) 558-3330 E: info@ffnsurveying.com

JOB NO. 23-477

SHEET 1/1

EXHIBIT A

A unit of land situated in the northeast one-quarter of Section 30 and the northwest one-quarter of Section 29, Township 8 South, Range 4 West, of the Willamette Meridian, Polk County, Oregon, being a portion of Monmouth Street lying west of Talmadge Road, and more particularly described as follows:

Beginning on the south line of that property conveyed to Knowles Properties, LLC, by Instrument Number 2009-000381, Polk County Deed Records, being approximately 45 feet west of the southwest corner of the Polk County Fire District No. 1 property as described in Book 227, Page 533, Polk County Deed Records, also being coincident with the north line of Monmouth Street;

thence, going easterly along the north line of said Monmouth Street approximately 766 feet to the southeast corner of that property conveyed to LS Prop Drop LLC by Instrument Number 2020-000636, Polk County Dreed Records;

thence, going southerly approximately 31 feet to the centerline of said Monmouth Street, being coincident with the Urban Growth Boundary;

thence, going westerly along said Urban Growth Boundary approximately 62 feet to an angle point therein;

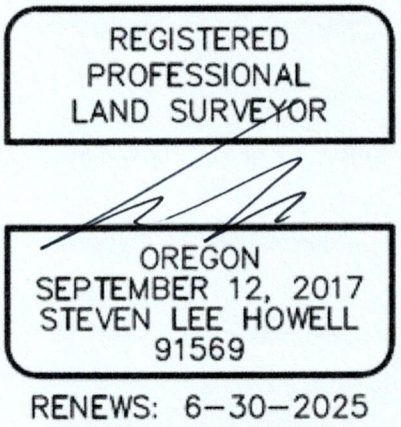
thence, going southerly along said Urban Growth Boundary approximately 23 feet to the south line of said Monmouth Street;

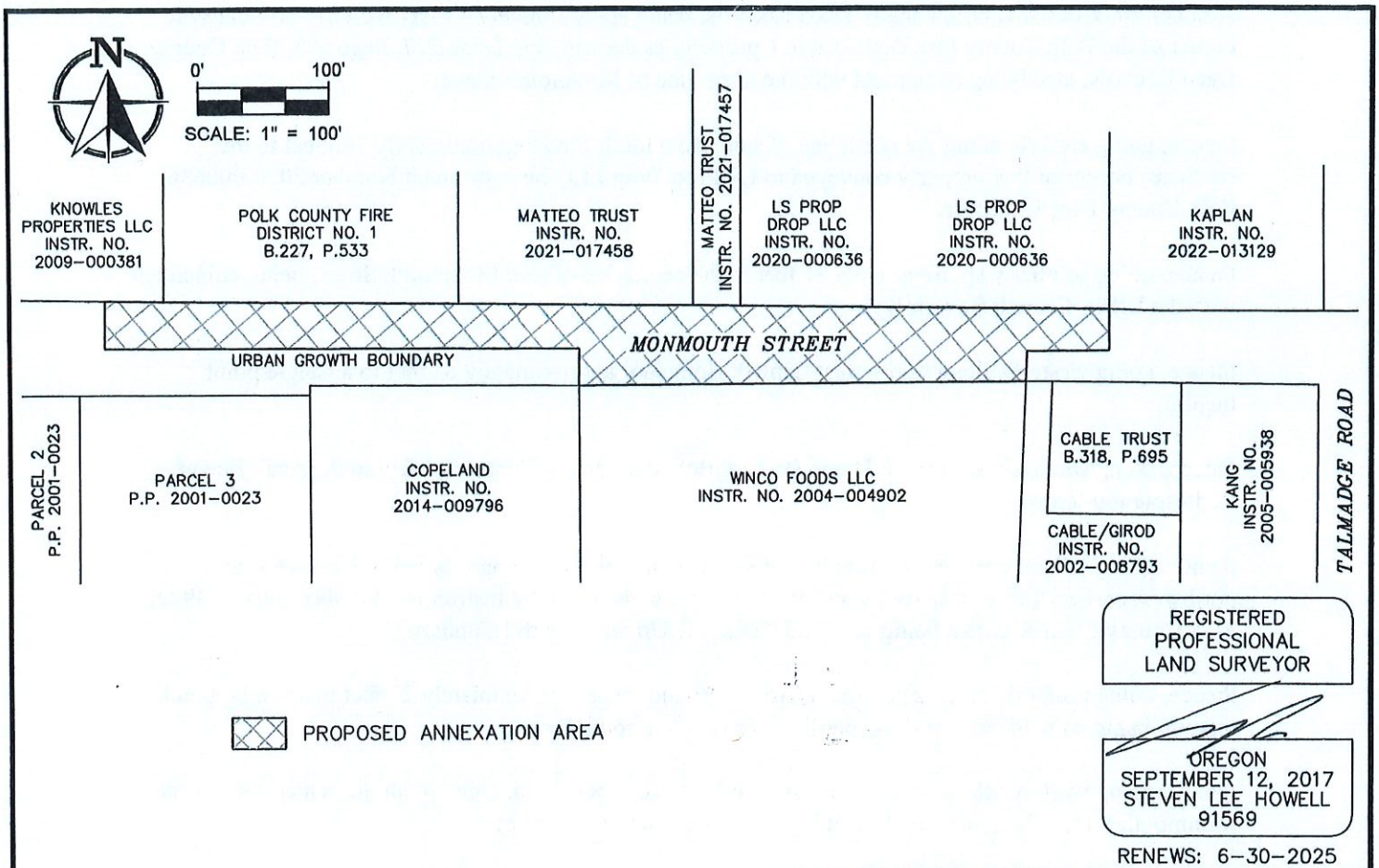
thence, going westerly along the south line of said Monmouth Street approximately 341 feet to the northwest corner of that property conveyed to Winco Foods, LLC, by Instrument Number 2004-004902, Polk County Deed Records, being coincident with the Urban Growth Boundary;

thence, going northerly along said Urban Growth Boundary for approximately 28 feet to an angle point therein, being coincident with the centerline of said Monmouth Street;

thence, going westerly along said Urban Growth Boundary, being coincident with the centerline of said Monmouth Street, for approximately 363 feet to an angle point therein;

thence, going northerly along said Urban Growth boundary for approximately 36 feet to the Point of Beginning.





REGISTERED PROFESSIONAL LAND SURVEYOR

OREGON
SEPTEMBER 12, 2017
STEVEN LEE HOWELL
91569

RENEWS: 6-30-2025

EXHIBIT B

IN THE NE 1/4 OF SECTION 30 & THE NW 1/4 OF SECTION 29
TOWNSHIP 8 SOUTH, RANGE 4 WEST, W.M.
POLK COUNTY, OREGON
DATE: SEPTEMBER 18, 2024

SURVEYED FOR: CITY OF INDEPENDENCE

FFN SURVEYING
7230 3rd Street SE #145, Turner, OR 97392
P: (503) 558-3330 E: info@ffnsurveying.com

JOB NO. 23-477

SHEET 1/1

EXHIBIT A

A unit of land situated in the southwest one-quarter of Section 16, Township 8 South, Range 4 West, of the Willamette Meridian, Polk County, Oregon, being that portion of Stryker Road lying within the Southern Pacific Railroad right of way and more particularly described as follows:

Beginning at the intersection of the centerline line of said Stryker Road with the westerly line of said railroad right of way, being coincident with the Urban Growth Boundary;

thence, going easterly along the centerline line of said Stryker Road approximately 32 feet to an angle point therein, being coincident with the centerline line of said railroad right of way;

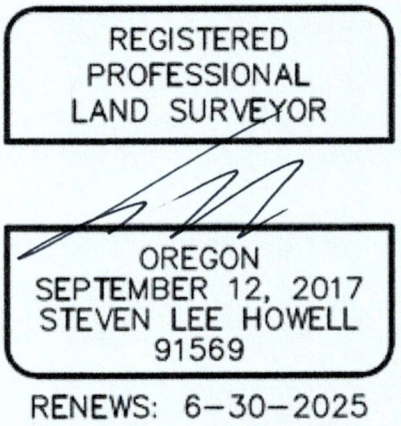
thence, going northerly along the centerline line of said railroad right of way, being coincident with the Urban Growth Boundary, approximately 26 feet to an angle point therein, being coincident with to the north line of said Stryker Road;

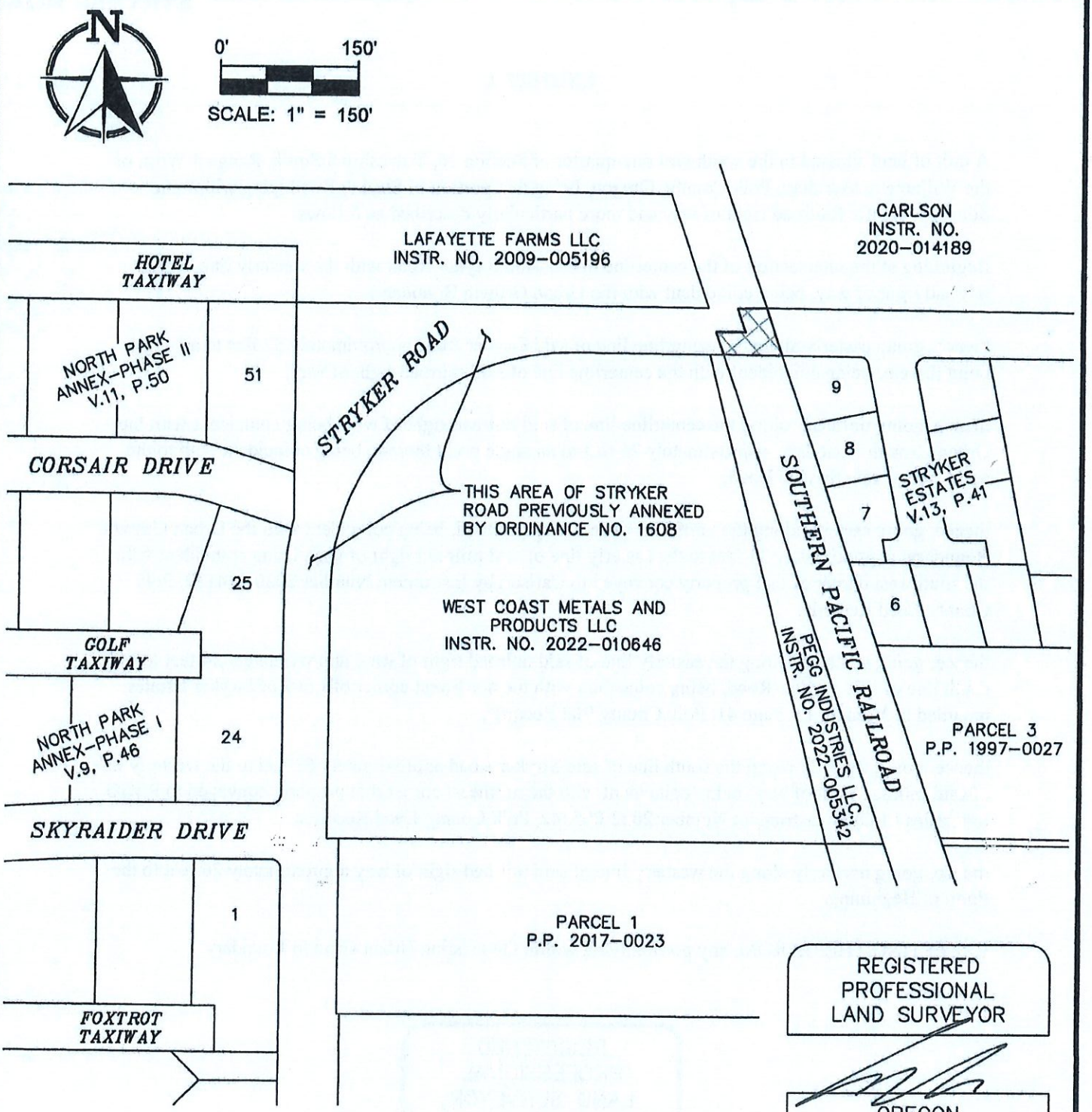
thence, going easterly along the north line of said Stryker Road, being coincident with the Urban Growth Boundary, approximately 31 feet to the easterly line of said railroad right of way, being coincident with the southwest corner of that property conveyed to Carlson by Instrument Number 2020-014189, Polk County Deed Records;

thence, going southerly along the easterly line of said railroad right of way, approximately 54 feet to the south line of said Stryker Road, being coincident with the northwest corner of Lot 9 of Stryker Estates recorded in Volume 13, Page 41, Polk County Plat Records;

thence, going westerly along the south line of said Stryker Road approximately 63 feet to the westerly line of said railroad right of way, being coincident with the northeast corner that property conveyed to PEGG Industries LLC, by Instrument Number 2022-005342, Polk County Deed Records;

thence, going northerly along the westerly line of said railroad right of way approximately 26 feet to the Point of Beginning.





REGISTERED
PROFESSIONAL
LAND SURVEYOR

OREGON
SEPTEMBER 12, 2017
STEVEN LEE HOWELL
91569

RENEWS: 6-30-2025

EXHIBIT B

IN THE SW 1/4 OF SECTION 16,
TOWNSHIP 8 SOUTH, RANGE 4 WEST, W.M.
POLK COUNTY, OREGON

DATE: SEPTEMBER 18, 2024

SURVEYED FOR: CITY OF INDEPENDENCE

FFN SURVEYING

7230 3rd Street SE #145, Turner, OR 97392
P: (503) 558-3330 E: info@ffnsurveying.com

JOB NO.
23-477

SHEET
1/1

ATTACHMENT C

Fred Evander

From: Nayalit Torreblanca
Sent: Monday, October 14, 2024 9:09 AM
To: Fred Evander
Subject: RE: New submission from Contact Us

Good morning, Fred,

We received this comment.

Thank you,

Nayalit Torreblanca
Accountant I/Utility Billing Clerk

Office 503.838.1212 | Fax 503.606.3282
www.ci.independence.or.us

INDEPENDENCE
Oregon's Story Begins Here

From: ntorreblanca@ci.independence.or.us <ntorreblanca@ci.independence.or.us>
Sent: Sunday, October 13, 2024 2:23 PM
To: Nayalit Torreblanca <ntorreblanca@ci.independence.or.us>
Subject: New submission from Contact Us

Name

Brian Smith

Email

@msn.com

Message

Concerning your attempts to annex rights-of-way along Talmadge Rd. and Olympic Dr, I want to press my rights to say NO. Your city is broke, and as a citizen of Monmouth, I do not wish to become part of anything to do with Independence. I will not pay for any developments, infrastructure, or otherwise and do not wish any development across from me in what is and should remain county land for farming use. Furthermore, your plan suggests Olympic Dr E as the through street when Madrona St is clearly the proper choice as it is designed for the additional traffic flow and ties directly to 99W. Please print this and submit it to the City Council so I might submit my protest of the proposed annexation on Talmadge Rd. and my resounding protest against a subdivision, especially one with multi-dwelling units across the street from my home on Olympic Dr. We, the citizens, DO NOT WANT FURTHER GROWTH in our small town. Our infrastructure is already overused and traffic has become unreasonable. Your city doesn't have the funds to pay for the new infrastructure, let alone to pay for proper maintenance on your current infrastructure, and as a citizen of Monmouth I WILL NOY HELP PAY FOR ANY INFRASTRUCTURE FOR INDEPENDENCE. Furthermore, the increased crime will only get worse with more people moving here which we have already seen with the shootouts and high speed chases around town these past couple of years. The simple fact is, the city doesn't have the funds, and does not need further growth when they cannot manage things properly for the current citizenship. You work for current citizens, not for developers or possible future citizens.

Brian D Smith
1997 Olympic Dr E
Monmouth, OR 97361

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

In the Matter of Surrendering	)
Jurisdiction Over Various	)
Roadways to the City of	)
Independence	)

ORDER NO. 25-06

WHEREAS, ORS 373.270(6)(a) states that the Board of Commissioners may surrender jurisdiction of any county road or portion thereof within a city to that city if its governing body initiates such action; and

WHEREAS, the governing body of the City of Independence has requested that Polk County surrender jurisdiction to the following:

All those portions of 13th Street, E Street, Gun Club Road, Talmadge Road and Stryker Road as described in the exhibits contained in the City of Independence Ordinance No. 1619 dated October 22, 2024.

WHEREAS, the City of Independence has annexed the above-described portions of Various Roadways to the City by passage of Ordinance # 1619 dated October 22, 2024; and

WHEREAS, upon surrender of the above-described property by Polk County, all of the above-described portions of roadways within the corporate limits of the City of Independence will be under the jurisdiction of the City; and

WHEREAS, the Board of Commissioners believes that it is in the public interest to surrender jurisdiction of the above-described County roads to the City of Independence,

NOW THEREFORE, the Polk County Board of Commissioners hereby Order that:

1) Polk County hereby surrenders jurisdiction over those portions of the various roadways described above to the City of Independence; and

2) The City of Independence is hereafter responsible for the surrendered roads as provided by ORS 373.270(7).

Dated this 9th day of April, 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

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: April 3, 2025

SUBJECT: Reclassification of a Road Maintenance Worker

Wednesday – April 9, 2025 (5 minutes)

RECOMMENDATION:
The Board of Commissioners approve the reclassification of a Road Maintenance Worker.

ISSUE:
Shall the Board approve the reclassifications?

DISCUSSION:
It is recommended that Peter McLeod, in Public Works, be reclassified from a Road Maintenance Worker to a Heavy Equipment Operator. Peter has been with the County two years and received the necessary experience for this reclassification. This is the normal trajectory for a Road Maintenance Worker after two years.

Peter is currently at step 6 of the Road Maintenance Worker position which is $5,201 monthly. If the reclassification is approved, he would move to step 6 of the Heavy Equipment Operator position which is $5,407.

Should the reclassification be approved, it would be effective April 1, 2025.

FISCAL IMPACT:
This reclassification will have an impact on the budget for FY 24-25 of approximately $3,200 including PERS contribution should it be for 12 months.

CONTRACT REVIEW SHEET

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

Department: Health Services | Consent Calendar Date: April 09, 2025

Contractor Name: PacificSource Community Solutions

Address: 3125 Chad Drive

City, State, Zip: Eugene, OR 97408

Effective Dates - From: January 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 24 months. This Agreement voids and replaces the previously signed, but not executed, version recorded as No. 25-12.

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 new 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 January, 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

January 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 01/01/2025
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 01/01/2025
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.

ADDENDUM

Polk County

01/01/2025

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.

ATTACHMENT B
Polk County
01/01/2025
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

01/01/2025

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

01/01/2025

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.

BEFORE THE BOARD OF COMMISSIONERS
FOR POLK COUNTY, OREGON

In the Matter of Participation in Funding	)
Activities of the Oregon Office for	)
Community Dispute Resolution	)

RESOLUTION NO. 25-07

WHEREAS, the Board of Commissioners believes that the settlement of disputes by mediation may lead to more long-lasting and mutually satisfactory agreements; and

WHEREAS, mediation may reduce the need for time-consuming and costly litigation; and

WHEREAS, the Oregon Legislature has charged the State of Oregon acting by and through the State Board of Higher Education on behalf of the University of Oregon for the University of Oregon School of Law (Grantor) with the responsibility to foster the development of community mediation programs by making grant monies available to participating counties; and

WHEREAS, Polk County has participated in Community Dispute Resolution since 1991; and

WHEREAS, any county wishing to participate must formally notify the commission of its intentions; now, therefore:

IT IS HEREBY RESOLVED THAT, Polk County hereby notifies the Commission of its desire to be a participant in the expenditure of funds for dispute resolution programs within Polk County, and Polk County agrees to engage in a selection process and to select as funding recipients those entities both qualified by the standards and guidelines adopted by the Commission and capable of and willing to provide services according to the rules adopted by the commission.

Dallas, Oregon, April 9, 2025

POLK COUNTY BOARD OF COMMISSIONERS

_____
Craig Pope, Chair

_____
Lyle Mordhorst, Commissioner

_____
Jeremy Gordon, Commissioner

Approved as to Form:

_____
Morgan Smith
County Counsel