CROOK COUNTY COURT MEETING
Crook County Annex | 320 NE Court St. | Prineville OR
WEDNESDAY, May 5, 2021 at 9:00 A.M.

Members of the public and media are welcome to attend in person with social distancing or via WebEx 1-408-418-9388; Access Code: 126 320 5412; Meeting Password: VFmR4z4PaM3

CONSENT AGENDA

(Routine matters which are not expected to generate discussion and are approved in a single vote. Any member of the Court may request removal of an item for separate discussion or vote.)

1. Approve Minutes of April 20, 2021 and April 27, 2021 Work Session and April 21, 2021 Regular Court Meeting
2. Approve IGA with City of Prineville for Paving Main Street
3. Approve Clerk Draw Down Account with Central Oregon Irrigation District
4. Approve Order 2021-21; Appointment to Natural Resource Advisory Committee
5. Approve Third Property Acquisition Resolution Weigand Bridge Project
6. Approve Memo to County Departments on Agenda Items
7. Approve GIS Professional Services Contract with City of Prineville
8. Approve Software Program Use Agreement with Oregon State University

SCHEDULED APPEARANCES

9. Bend Racing Request to use Courthouse Lawn — Requester: Jonathan Cavazos (10 Minutes)

DISCUSSION

10. Order 2021--22Budget Transfer Appropriations — Requester: Janet Pritiskutch (10 Minutes)
11. Public Hearing: Order 2021-23, FY 21 Supplemental Budget — Requester: Janet Pritiskutch (10 Minutes)
12. Consideration of Coordinated Care Organization Medicaid Services Agreement, Pacific Source/ Community Mental Health Programs — Requester: Eric Blaine (5 Minutes)
13. Community Mental Health Program Funding Agreement #166039, Plus First Amendment, for Behavioral Health, Addictions, Problem Gambling — Requester: Eric Blaine (5 Minutes)
14. Recommendation for Award of Electric Charging Station Installation Contract — Requester: Eric Blaine (5 Minutes)
15. Substance Use Disorder Treatment and Recovery Services RFP — Requester: John Eisler (5 Minutes)
16. Drought Emergency Declaration — Requester: John Eisler (5 Minutes)

EXECUTIVE SESSION – None Scheduled

**The Court may add additional items arising too late to be part of this Agenda. Agenda items may be rearranged to make the best use of time.*
**The meeting location is accessible to persons with disabilities. If additional accommodations are required, please submit your request 48 hours prior to the meeting by contacting County Administration at 541-447-6555.*

NOTICE AND DISCLAIMER

The Crook County Court is the governing body of Crook County and holds public meetings (generally on the first and third Wednesday of each month) to deliberate upon matters of County concern. As part of its efforts to keep the public apprised of its activities, the Crook County Court has published this PDF file. This file contains the material to be presented before the County Court for its next scheduled regular meeting.

Please note that while County staff members make a dedicated effort to keep this file up to date, documents and content maybe added, removed or changed between when this file is posted online and when the County Court meeting is held. The material contained herein maybe changed at any time, with or without notice.

CROOK COUNTY MAKES NO WARRANTY OF ANY KIND, EXPRESSED OR IMPLIED, INCLUDING ANY WARRENTY OF MERCHANTABILITY, ACCURACY, FITNESS FOR A PARTICULAR PURPOSE OR FOR ANY OTHER MATTER. THE COUNTY IS NOT RESPONSIBLE FOR POSSIBLE ERRORS, OMMISSIONS, MISUSE OR MISINTERPERTATION.

Please also note that this file does not contain any materials scheduled to be discussed at an executive session or material the access to which maybe restricted under the terms of Oregon law.

If you are interested in obtaining additional copies of any of the documents contained herein, they maybe obtained by completing a Crook County Public Records Request form. Request forms are available on the County's website.

CROOK COUNTY COURT MINUTES
OF APRIL 20, 2021 WORK SESSION
Open Portion

Be It Remembered that the Crook County Court met in a regularly scheduled Work Session on April 20, 2021, at 9:00 a.m. in the Administration Conference room located at 203 NE Court Street, Prineville, Oregon 97754.

Court Members Present: Judge Seth Crawford, Commissioner Jerry Brummer and Commissioner Brian Barney
Absentees: None
Others Present in Person or Via WebEx: Legal Counsels Eric Blaine and John Eisler; Administration Executive Assistant Amy Albert; Deputy Director Katie Plumb; Community Development Director Ann Beier; Code Compliance Officer Louis Seals; Project Manager Lori Furlong; Librarian April Witteveen; IT Director Troy Poncin; Sheriff John Gautney and Natural Resources Policy Coordinator Tim Deboodt.

WORK SESSION

The meeting was **called to order at 9:00 a.m.**

ADDITIONS/REMOVALS: None

Agenda Item #1, Covid-19 Update: Health Department Deputy Director Katie Plumb provided the Court with a Covid-19 update. The County will move into the High-Risk Category Friday, April 23, 2021. The Health Department issued a press release yesterday regarding later hours for the vaccination clinic beginning next week. The Health Department received one-thousand extra doses of the Pfizer vaccine to be distributed throughout the community.

Agenda Item #2, Using a Hearings Officer for Code Compliance Cases: Code Compliance Officer Louis Seals approached the Court regarding using a hearings officer for code compliance cases. Currently compliance issues are referred to the Circuit Court but at this time these cases are a low priority, and the Circuit Court is backlogged due to Covid-19 restrictions. Many other Counties use a hearings officer as a first step in hopes of bringing cases into compliance before having to refer them to Circuit Court. In most cases this process has been successful at keeping many cases out of Circuit Court. Moving forward John Eisler will make draft changes to the County Code and bring them back before a Work Session for discussion.

Agenda Item #3, Millican Laydown Yard Status: John Eisler discussed the Staging Area Lease Agreement between Cupertino Electric Inc. and the County, specifically paragraph three, sections D and E. The concern is how the land should be vacated, to make this determination members of the Court will visit the site.

EXECUTIVE SESSION

None Scheduled

There being no further business before the Court, the meeting was **adjourned at 9:36 a.m**.

Respectfully submitted,

Amy Albert

CROOK COUNTY COURT MINUTES
OF April 27, 2021 WORK SESSION
Open Portion

Be It Remembered that the Crook County Court met in a regularly scheduled Work Session on April 27, 2021, at 9:00 a.m. in the Administration Conference room located at 203 NE Court Street, Prineville, Oregon 97754.

Court Members Present: Judge Seth Crawford, Commissioner Jerry Brummer and Commissioner Brian Barney
Absentees: None
Others Present in Person or Via WebEx: Legal Counsels Eric Blaine and John Eisler; Administration Executive Assistant Amy Albert; HR Director Kim Barber; Sheriff John Gautney; Librarian April Witteveen; IT Director Troy Poncin; Road Master Bob O'Neal; Accounting Manager Janet Pritiskutch; Treasurer Galen Carter; Senior Accountant Christine Kurtz; Assessor Jon Soliz; Clerk Cheryl Seely; Director Ann Beier; Deputy Director Katie Plumb and Planner Katie McDonald.

WORK SESSION

The meeting was **called to order at 9:00 a.m.**

Agenda Item #1, Covid-19 Update: Deputy Director of the Health Department Katie Plumb provided the Court with a Covid-19 update. There has been a recent surge in Covid-19 cases, in the past two weeks one hundred six individuals have tested positive. Beginning today there are evening appointments available at the vaccination clinic, through the clinic will soon end and vaccinations will be administered at the Health Department.

Agenda Item #2, IT Fees from Clerk's Office – Review Use of Fee's: Accounting Manager Janet Pritiskutch requested the Court provide updated direction for IT fee collection that was established in 2005. Currently there is a $5 technology fee collected on recordings through the Clerks Office, Ms. Pritiskutch is proposing the fee go toward computer replacement. Ms. Pritiskutch will draft an Order designating the use of the fee collection.

Agenda Item #3, Parks and Rec District Fee Increase: Community Development Director Ann Beier informed the Court about a public notice that will be sent out by Parks and Rec involving a fee increase. Ms. Beier's concern with the public notice is a statement regarding a potential fee increase to a maximum of $40,000. While the fees won't be increased to this amount the County's logo is on the public notice and the County had no input on this matter as Parks and Rec is a special district. If members of the public call concerning this matter, they are to be referred to Parks and Rec.

Agenda Item #4, Update/Get Signatures for CAFFA Grant: Surveyor Jon Soliz requested a signature from the Court for a CAFFA Grant that is due Monday, May 3, 2021. Due to the time constraints the grant was signed by Judge Crawford.

MOTION to approve form eight of the 2021-2022 of the grant application. Motion seconded. No further discussion. Motion carried 3-0.

Agenda Item #5, Courthouse Seismic Retro Fit Evaluation: Commissioner Barney updated the Court on the Courthouse tour with Walker Structural Engineering and Kirby Nagelhout Construction regarding the seismic retro fit evaluation of the Courthouse. A cost estimate should be provided by next week so the County may take the next steps toward a seismic retro fit.

Addition - Correspondence to Governor Brown: Judge Crawford presented the Court with two letters to Governor Brown, one from AOC and the other from Crook County, requesting reconsideration to the approach to virus mitigating factors. The Court will send both letters to Governor Brown.

MOTION to approve sending Crook County and AOC letters to Governor Brown with signatures. Motion seconded. No further discussion. Motion carried 3-0.

EXECUTIVE SESSION

None Scheduled

There being no further business before the Court, the meeting was **adjourned at 9:29 a.m.**

Respectfully submitted,

Amy Albert

CROOK COUNTY COURT MINUTES
OF APRIL 21, 2021 REGULAR MEETING
Open Portion

Be It Remembered that the Crook County Court met in a Regular Court meeting on April 21, 2021, at 9:00 a.m. in the County meeting room located at 320 NE Court Street, Prineville, Oregon 97754.

Court Members Present: Judge Seth Crawford, Commissioner Jerry Brummer and Commissioner Brian Barney
Absentees: None
Others Present in Person or Via WebEx: Legal Counsels Eric Blaine and John Eisler; Administration Executive Assistant Amy Albert; Community Development Director Ann Beier; Clerk Cheryl Seely; Natural Resources Policy Coordinator Tim Deboodt; Manager Casey Daly; Senior Accountant Christine Kurtz; GIS Manager Levi Roberts; Shawn Cross; Rich Alm; Kim Nicholsen; Wanda Smith; Tom Casselman; James Staniford; Mike Ervin; Matt McCaw; Barbara Fontaine; Renee Karter; Robin Olson; Eric Bush; Arleen Curths; Frank Porfily; Tim Chandler; Zach Dunn; Barclay Wyss; Sondy Wyss; Kristie Voakes and Miles Voakes.

REGULAR SESSION

The meeting was **called to order at 9:00 a.m.**

ADDITIONS/REMOVALS: None

MOTION to approve the Consent Agenda as presented. Motion seconded. No discussion. Motion carried 3-0.

Appearances / Item #7: Shawn Cross Crook County Captain of the Greater Idaho Movement appeared before the Court with a SEL 801 Notice of Measure Election for the Court's consideration. County Counsel and the County Clerk's Office will review the SEL 801 and respond to Mr. Cross in writing. The Court replied to questions from members of the community regarding this topic and provided suggestions on how to proceed with the Greater Idaho Movement.

Appearances / Item #8: Rich Alm updated the Court on rate renewals for the County's medical, dental and long-term disability.

Discussion item #9: Parole and Probation received one response to their Batterer's Intervention and Prevention Program RFP from Best Care Treatment Services. The response met the requirements of the RFP and Best Care is a qualified treatment provider. It is recommended that Best Care Treatment Services be awarded the Batterer's Intervention and Prevention contract.

MOTION to award Best Care Treatment Services the Batterer's Intervention and Prevention Contract to be signed out of Court. Motion seconded. No further discussion. Motion carried 3-0.

Discussion item #10: John Eisler presented the Court with Ordinance 323 for the third and final reading. The first reading was held on March 17, 2021 and the second reading was held on April 7, 2021, after some minor changes were made to the Ordinance. Judge Crawford opened a public hearing for the third reading of Ordinance 323 by title, an Ordinance amending Crook County code chapters 18.12, 18.124, 18.170 and 18.172 regarding editing code language for consistency with state law and removing incorrect citations. There being no discussion or objections the public hearing was closed, and the Ordinance was approved.

MOTION to read Ordinance 323 by title only. Motion seconded. No further discussion. Motion carried 3-0.

MOTION to approve Ordinance 323 as written. Motion seconded. No further discussion. Motion carried 3-0.

Discussion item #11: The County has requested patrician of two parcels of property identified as Township 15S, Range 15E WM, Tax Lot 300. The patrician will create a septate tax lot for the airport property and create a new forty acer parcel. This patrician has been approved by both the City of Prineville and Crook County.

MOTION to sign work order 20-5448. Motion seconded. No further discussion. Motion carried 3-0.

At 10:21 a.m. the Court convened into Executive Session under the following statute(s): ORS 192.660(2)(e) For the purpose of conducting deliberations with persons designated by the governing body to negotiate real property transactions.

EXECUTIVE SESSION

At the conclusion of the Executive Session, the County Court convened back into Open Session, inviting members of the public into the meeting room.

MOTION to direct staff to proceed as discussed in Executive Session. Motion seconded. No further discussion. Motion carried 3-0.

Respectfully submitted,

Amy Albert

INTERGOVENRMENTAL AGREEMENT
For Chip Seal on Lynn Boulevard, Prineville

This intergovernmental agreement (the "Agreement") is made by and between Crook County, a political subdivision of the State of Oregon ("County") and the City of Prineville, an Oregon municipal corporation ("City"). As used herein, County and City may each be referred to as a Party, or collectively as the Parties.

RECITALS

A. *Whereas*, the Parties are empowered pursuant to ORS 190.010 to enter into intergovernmental agreements for the performance of any or all functions and activities that a party to the agreement, its officers or agencies, have authority to perform; and

B. *Whereas*, the Parties are each authorized to perform road maintenance services, including but not limited to chip sealing, flagging, traffic control, and the distribution of rock and oil, over the roadways within their respectively jurisdictions; and

C. *Whereas*, the Parties wish to allocate responsibilities for a one-time road maintenance project within Prineville, Oregon, as more particularly described herein.

AGREEMENT

Now, therefore, for good and valuable consideration, the sufficiency of which is acknowledged, and intending to be bound thereby, the Parties agree as follows:

1. Incorporation of Recitals: The above Recitals are incorporated into and made a part of this Agreement, as terms of contract and not mere recitals.

2. Chip Sealing:

   a. County will undertake to chip seal 1.3 miles of roadway on Main Street in Prineville, Oregon, from Lynn Blvd thence traveling Southward along Main Street to the urban growth boundary. County will be responsible for obtaining any necessary permits and for traffic management while the work is being performed.

   b. County will be responsible for complying with the public works and public improvement requirements of the Bureau of Labor and Industries, including, but only to the extent applicable, payment of wages, submission of WH-81 from, and notification to BOLI.

3. Payment:

   a. County will monitor its expenses using a cost accounting basis, complete with all material, labor, and equipment. City will be charged for County's

actual costs, provided that City will not be responsible for costs in excess of $38,833.00 without City's approval, confirmed in writing.

b. City will remit payment to County within thirty (30) days of City's receipt of County's invoice. County will provide City with such accounting and other documentation verifying County's expenses as City may reasonably request.

4. Scheduling: The work under this Agreement will be on a date and time as the Parties may mutually agree. The Parties estimate that the chip sealing will require two (2) 10-hour workdays to complete.

5. Effective Date/Duration: This Agreement becomes effective when signed by both Parties, and will continue in force until October 31, 2021, unless sooner terminated as described herein.

6. Termination: Either party may terminate this Agreement upon thirty (30) days' prior written notice. Termination or expiration of this Agreement will not prejudice any right or claim which accrues prior to such termination or expiration.

7. Use of Right of Way: For the duration of this Agreement, City grants to County permission to occupy and operate within City's rights-of-way and property as may be reasonably necessary to perform the services under this Agreement. At the completion of the chip sealing, County will restore such City rights-of-way and properties to the same condition as existed before the work began.

8. Assignment: Neither this Agreement nor any of the rights granted by this Agreement may be assigned or transferred by either Party. Notwithstanding the foregoing, County may engage the services of subcontractors for some or all of the work described herein, provided, however, that County will remain responsible to City for the completion of the services.

9. Binding Effect: The terms of this Agreement shall be binding upon and inure to the benefit of each of the Parties and each of their respective administrators, agents, representatives, successors, and assigns.

10. Agency and Partnership: Neither Party is, by virtue of this Agreement, a partner or joint venturer with the other Party and neither Party shall have any obligation with respect to the other Party's debts or liabilities of whatever kind or nature.

11. Indemnification:

damages, liabilities, costs, and expenses of any nature resulting from or arising out of, or relating to the activities of City or its officers, employees, contractors, or agents under this Agreement.

b. To the extent permitted by Article XI, Section 10, of the Oregon Constitution and the Oregon Tort Claims Act, ORS 30.260 through 30.300, County shall defend, save, hold harmless, and indemnify City and its officers, employees, and agents from and against all claims, suits, actions, losses, damages, liabilities, costs, and expenses of any nature resulting from or arising out of, or relating to the activities of County or its officers, employees, contractors, or agents under this Agreement.

c. Neither party shall be liable to the other for any incidental or consequential damages arising out of or related to this Agreement. Neither party shall be liable for any damages of any sort arising solely from the termination of this Agreement or any part hereof in accordance with its terms.

12. Non-Discrimination: Each Party agrees that no person shall, on the grounds of race, color, creed, national origin, sex, marital status, age, or sexual orientation, suffer discrimination in the performance of this Agreement when employed by either Party. Each Party agrees to comply with Title VI of the Civil Rights Act of 1964 as amended, Section V of the Rehabilitation Act of 1973 as amended, and all applicable requirements of federal and state civil rights and rehabilitation statutes, rules, and regulations. Additionally, each Party shall comply with the Americans with Disabilities Act of 1990 as amended, ORS 659.425, and all regulations and administrative rules established pursuant to those laws.

13. Attorney fees: In the event an action, lawsuit, or proceeding, including appeal therefrom, is brought for failure to observe any of the terms of this Agreement, each Party shall bear its own attorney fees, expenses, costs, and disbursements for said action, lawsuit, proceeding, or appeal.

14. No Waiver of Claims: The failure of either Party to enforce any provision of this Agreement shall not constitute a waiver by that Party of that provision or of any other provision of this Agreement.

15. Severability: Should any provision or provisions of this Agreement be construed by a court of competent jurisdiction to be void, invalid, or unenforceable, such construction shall affect only the provision or provisions so construed, and shall not affect, impair, or invalidate any of the other provisions of this Agreement which shall remain in full force and effect.

16. Applicable Law: This Agreement shall be governed by and interpreted in accordance with the laws of the State of Oregon, with venue reserved for the Circuit Court of Crook County.

17. Entire Agreement: This Agreement constitutes the entire agreement between the Parties concerning the subject matter hereof, and supersedes any and all prior or contemporaneous agreements or understandings between the Parties, if any, whether written or oral, concerning the subject matter of this Agreement which are not fully expressed herein. This Agreement may not be modified or amended except by a writing signed by both Parties.

18. Counterparts: This Agreement may be executed in one or more counterparts, including electronically transmitted counterparts, which when taken together shall constitute one and the same original. Facsimiles and electronic transmittals of the signed document shall be binding as though they were an original of such signed document.

CROOK COUNTY COURT

_____
Seth Crawford, County Judge

_____
Jerry Brummer, County Commissioner

_____
Brian Barney, County Commissioner

Date _____

CITY OF PRINEVILLE

_____
Jason Beebe, Mayor

Date _____

_____
Steve Forrester, City Manager

Date _____

Crook County Counsel's Office

Mailing: 300 NE Third St., Prineville, OR 97754 • Phone: 541-416-3919
Physical: 267 NE 2nd St., Ste 200, Prineville, OR 97754 • Fax: 541-447-6705

MEMO

TO: Crook County Court

FROM: County Counsel's Office (Regi)

DATE: April 14, 2021

RE: Clerk Draw Down Account with Central Oregon Irrigation District (COID)
Our File No.: Clerk 73

Enclosed is a service agreement between the County and COID in which the County will provide access to the Clerk's client portal. The County and COID have been in a substantially similar agreement since 2015. This new agreement is basically an extension of what was in place.

Cheryl Seely recommends its approval. Please let me know if you have any questions.

Please place this memo and the attached document(s) on the Wednesday, May 5, 2021 County Court Agenda as a CONSENT ITEM, for approval and signatures.

SERVICE AGREEMENT

This agreement entered into by and between the Crook County, a political subdivision of the State of Oregon (hereinafter "County"), and Central Oregon Irrigation District, hereinafter "Subscriber" and effective March 19, 2021.

WITNESSETH

It is hereby agreed by and between the parties above mentioned, for and in consideration of the mutual promises hereinafter stated as follows:

Duration: The duration of this agreement shall be for one (1) year beginning on the effective date. This agreement shall automatically renew each year for a consecutive period of five (5) years, unless terminated or extended according to the provisions of this Agreement

1. **County's Responsibilities:** Crook County Clerk's Office will maintain a draw down account under Subscriber's name. Clerk's Office shall notify Subscriber when such account requires additional funds. Charges or rates for services provided by County in accordance with its Fee Schedule shall be withdrawn from said draw down account at the time of service. Subscriber authorizes County to automatically withdraw monies provided by Subscriber in the draw down account for each provided service. In the event the draw down account is depleted and payment is not received by County as set forth herein, services may be withheld until payment is received. If draw down account is inactive and not used for a period of 6 months, County shall terminate this contract and refund Subscriber the remaining monies held in the draw down account.
2. **Termination:** This contract may be terminated by either party with thirty (30) days written notice to the other party.
3. **Severability:** The parties agree that if any term or provision of this Contract 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 effected, and the rights and obligations of the parties shall be construed and enforced as if the Contract did not contain the particular term or provision held to be invalid.
4. **Modification:** This agreement is the entire agreement and any modifications must be in writing signed by both parties.
5. **Assignment:** Neither Subscriber nor County may assign this agreement without the prior written consent of the other.
6. **No Authority to Bind Crook County.** Subscriber has no authority to enter into contracts on behalf of Crook County. This Agreement does not create a partnership between the parties.
7. **Liability.** Each party is responsible for and agrees to hold each other harmless for all liability, losses, damages, costs, or expenses which arise out of the negligent act

or omission of that party while acting in the course of their involvement with this Agreement.

8. **Governing Law and Venue.** Any dispute under this Agreement shall be governed by Oregon law with venue being located in Crook County, Oregon.
9. **Compliance with the Laws.** Subscriber agrees to comply with the provisions of this Agreement, Title VI of the Civil Rights Act of 1964, and with all applicable federal, state, county, and local statutes and rules.

Crook County

Seth Crawford, Crook County Judge
Date: 5/5/21

Jerry Brummer, County Commissioner
Date: 5/5/21

Brian Barney, County Commissioner
Date: 5/5/21

Read and Approved:

Cheryl Seely, Crook County Clerk — Date: 4/14/21

Approved for Legal

John Eisler, Asst. County Counsel — Date

Subscriber

By: _____

Its: CRAIG HORRELL

Title: MANAGER

Date: 4.13.21

IN THE COUNTY COURT OF THE STATE OF OREGON

FOR THE COUNTY OF CROOK

IN THE MATTER OF THE APPOINTMENT TO NATURAL RESOURCE ADVISORY COMMITTEE

ORDER 2021-21

WHEREAS, volunteers are essential to the operation of the county government; and

WHEREAS, the Court has carefully considered the skills and talents of the applicants and the needs of the boards which has a vacancy requiring appointments, and based upon recommendation of Boards and Committees:

NOW, THEREFORE, it is hereby **ORDERED** that that the Crook County Court makes the following appointment to the Crook County Boards and Committees:

Board	**Appointee**	**Term**	**Oath required**
Natural Resources Advisory Committee	Jace Rhoden	4 – Year Term Expiring 12-31-2024	No
Natural Resources Advisory Committee	Cliff Kiser	2 – Year Term Expiring 12-31-2022	No
Natural Resources Advisory Committee	Casey Kaiser	1 – Year Term Expiring 12-31-2021	No

DATED this 5th day of May 2021.

Seth Crawford
County Judge

Jerry Brummer
County Commissioner

Brian Barney
County Commissioner

Crook County Legal Counsel

Mailing: 300 NE Third St., Rm 10, Prineville, OR 97754 • Phone: 541-416-3919
Physical: 267 NE 2nd St., Ste 200, Prineville, OR 97754 • Fax: 541-447-6705

MEMO

TO: Crook County Court

FROM: Crook County Legal Counsel's Office

DATE: April 28, 2021

RE: Third resolution for Weigand Bridge repair project
Our File No.: Road # 321(B)

As you recall, the County is undertaking a bridge renovation project across an irrigation canal along Weigand Road. The County was advised that the engineering plans required the acquisition of additional right-of-way. ODOT, which is responsible for drafting the legal description for the property, requires the County to execute resolutions which specifically recite that legal description.

This will be the third resolution approved by the County for this project. The first was approved in September 2020, and a second was approved in February to correct an error in the first resolution's legal description. This third resolution is meant to address an error in the second description, "where the lot line adjustment was not correctly shown or described."

The terms of this third resolution are otherwise substantially similar to those of the first two.

April 28 update: The County received a fourth modification to the legal description this morning. What is in your agenda packets is the third resolution, with the fourth (not third) description.

Please place this memo and the attached document(s) on the Wednesday, May 5, 2021 County Court Agenda as a CONSENT ITEM, for approval and signatures.

RESOLUTION EXERCISING THE POWER OF EMINENT DOMAIN
Right of Way Services
(replaces prior Resolutions signed 9/16/20 and 2/17/21)

WHEREAS, Crook County, a political subdivision of the State of Oregon, hereafter referred to as "Crook," may exercise the power of eminent domain pursuant to ORS 203.135 and the laws of the State of Oregon generally, when the exercise of such power is deemed necessary by the Crook County Court, Crook's governing body, to accomplish public purposes for which Crook has responsibility; and

WHEREAS, Crook has the responsibility of providing safe transportation routes for commerce, convenience and to adequately serve the traveling public; and

WHEREAS, the project known as Weigand Road Bridge Over Irrigation Ditch (Powell Butte) Bridge No. Br13C24, has been planned in accordance with appropriate engineering standards for the construction, maintenance or improvement of said transportation infrastructure such that property damage is minimized, transportation promoted, travel safeguarded; and

WHEREAS, to accomplish the project or projects set forth above it is necessary to acquire the interests in the property described in "Exhibit A" attached to this Resolution and, by this reference incorporated herein.

NOW, THEREFORE, BE IT HEREBY RESOLVED by the Crook County Court that:

1. The foregoing statements of authority and need are, in fact, the case. The project or projects for which the property is required and is being acquired are necessary in the public interest, and the same have been planned, designed, located, and will be constructed in a manner which will be most compatible with the greatest public good and the least private injury.

2. The power of eminent domain is hereby exercised with respect to each of the interests in property described in Exhibit A to this Resolution. Each is acquired subject to payment of just compensation and subject to procedural requirements of Oregon law.

3. This Resolution replaces and supersedes the former Resolution signed by the County Court on September 16, 2020, and updates the entire interest in the property, as described in the attached Exhibit A.

4. The Crook County Court is authorized and requested to attempt to agree with the owner and other persons in interest as to the compensation to be paid for each acquisition, and, in the event that no satisfactory agreement can be reached, to commence and prosecute such condemnation proceedings as may be necessary to finally determine just compensation or any other issue appropriate to be determined by a court in connection with the acquisition. This authorization is not intended to expand the jurisdiction of any court to decide matters determined above or determinable by the Crook County Court.

5. Crook expressly reserves its jurisdiction to determine the necessity or propriety of any acquisition, its quantity, quality, or locality, and to change or abandon any acquisition.

APPROVED and SIGNED this 5th day of May 2021.

CROOK COUNTY COURT

Seth Crawford County Judge	Jerry Brummer County Commissioner	Brian Barney County Commissioner

EXHIBIT A

Parcel 1 – Permanent Easement For Highway Right-Of-Way Purposes

A parcel of land located in the Northeast one-quarter of Section 34, Township 15 South, Range 14 East, Willamette Meridian, Crook County, Oregon and being a portion of that property as described in that Boundary Line Adjustment, Recorded December 13, 2019, as Instrument No. 2019-297153 of Crook County Records, said Parcel 1 being that portion of said property contained in a strip of land 10 feet in width, said 10 foot wide strip lying Northerly of the following described line:

Commencing at a 2" aluminum cap marking the East One-quarter corner of said Section 34; thence N89°24'14"W, along the East-West centerline of said Section 34, a distance of 1098.14 feet; thence N00°35'46"E, 20.00 feet to the Northerly right-of-way line of SW Weigand Road and the Point of Beginning of said described line; thence N89°24'14"W, along said Northerly right-of-way line, 275.00 feet to the Terminus of said described line, said Terminus bearing N27°17'00"W, 2989.56 feet from a 2 1/2" aluminum cap marking the Southeast corner of said Section 34.

Parcel 1 contains 2,750 square feet, or 0.063 acres, more or less.

Parcel 2 – Temporary Easement For Work Area (5 years or duration of project, whichever is sooner)

A parcel of land located in the Northeast one-quarter of Section 34, Township 15 South, Range 14 East, Willamette Meridian, Crook County, Oregon and being a portion of that property as described in that Boundary Line Adjustment, Recorded December 13, 2019, as Instrument No. 2019-297153 of Crook County Records, said Parcel 2 being that portion of said property contained in a strip of land 20 feet in width, said 20 foot wide strip lying Northerly of the following described line:

Commencing at a 2" aluminum cap marking the East One-quarter corner of said Section 34; thence N89°24'14"W, along the East-West centerline of said Section 34, a distance of 1010.75 feet; thence N00°35'46"E, 20.00 feet to the Northerly right-of-way line of SW Weigand Road and the Point of Beginning of said described line; thence N89°24'14"W, along said Northerly right-of-way line, 530.55 feet to the Terminus of said described line, said Terminus bearing N30°03'25"W, 3071.79 feet from a 2 1/2" aluminum cap marking the Southeast corner of said Section 34.

Excepting therefrom said Parcel 1

Parcel 2 contains 7,861 square feet, or 0.180 acres, more or less.

Said Parcels being **subject to** Easements, Reservations, Covenants and Restrictions of Record or In View.

Bearings and distances are based on the Oregon State Plane Coordinate System, North zone, NAD83(2011).

For purposes of these descriptions, said East One-quarter corner of Section 34 bears N00°03'14"E, 2622.69 feet from said Southeast corner of Section 34; All as shown on Exhibit B, the easement sketch attached to these descriptions.

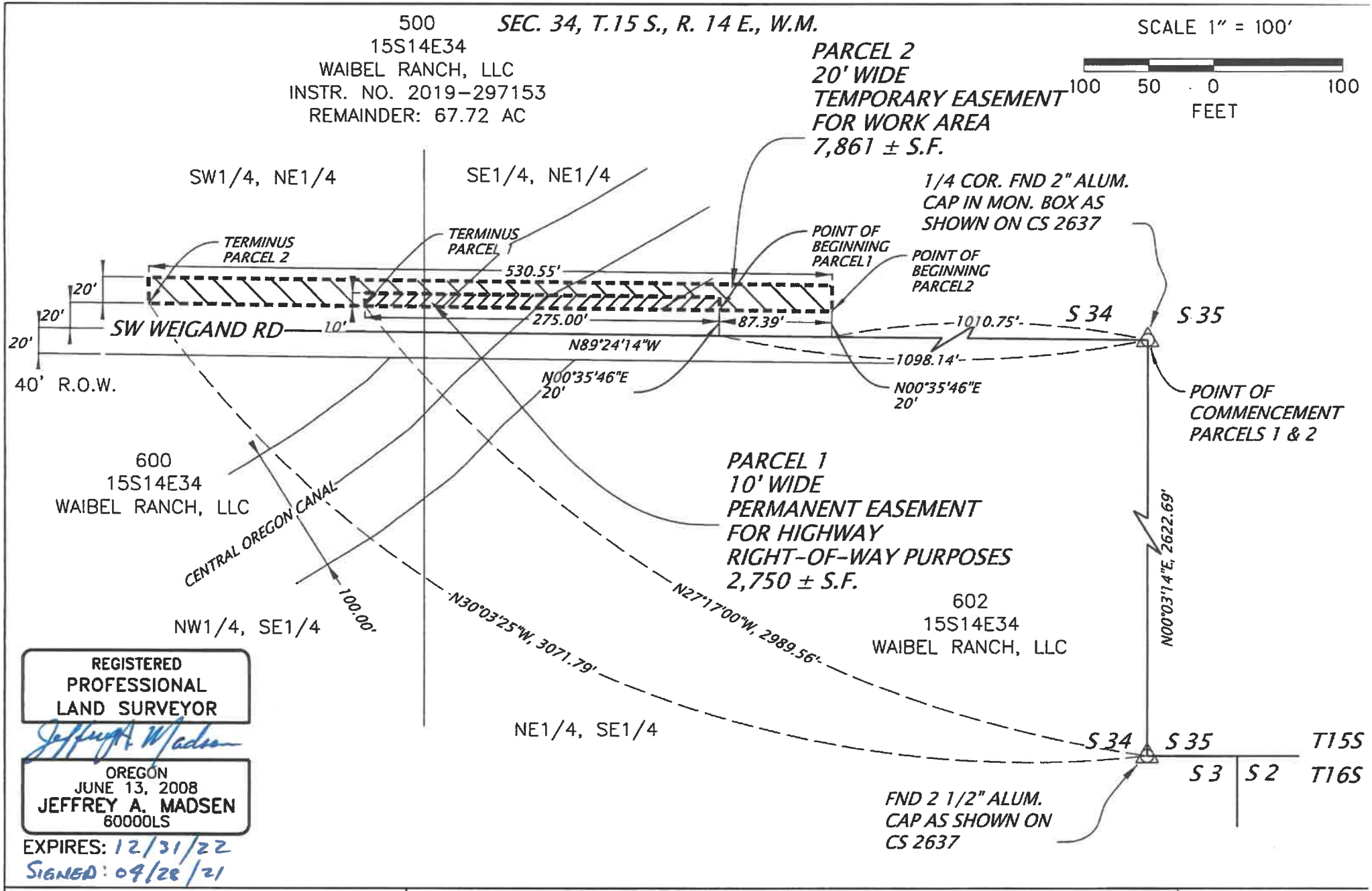
REGISTERED
PROFESSIONAL
LAND SURVEYOR

Jeffrey A. Madsen

OREGON
JUNE 13, 2008
JEFFREY A. MADSEN
60000LS

EXPIRES: 12/31/22

SIGNED: 04/28/21



REGISTERED
PROFESSIONAL
LAND SURVEYOR

OREGON
JUNE 13, 2008
JEFFREY A. MADSEN
60000LS

EXPIRES: 12/31/22
SIGNED: 04/28/21

OREGON DEPARTMENT
OF TRANSPORTATION
RIGHT OF WAY
ENGINEERING
EXHIBIT A, 3 OF 3

Section	SW WEIGAND ROAD - CENTRAL OREGON CANAL BRIDGE	Scale	1" = 100'
Highway	SW WEIGAND ROAD	Date	04-28-2021
County	CROOK	File	9672001
Purpose	PERM. EASE. FOR HWY ROW & TEMP. EASE.		

Crook County

Mailing: 300 NE 3rd Street • Prineville, Oregon 97754
Physical: 203 NE Court Street • Prineville, Oregon 97754
Phone (541) 416-6555 • FAX (541) 416-3891

May 5, 2021

Re: Guidance on placing matters on the agenda for County Court meetings and weekly work session meetings

We thought it would be helpful to provide written guidance on when and how to place matters on the agendas for the twice-monthly County Court meetings and the weekly work sessions. Some matters are better resolved at regular meetings. Other matters can be discussed at either meeting equally well.

1. The General Rule

The general rule for agenda items is that if a decision needs to be made by the County Court, such as approving an agreement, making a motion, or otherwise making a firm commitment on behalf of the County, it is best to have those matters on the agendas of regular (twice-monthly) County Court meetings.

The regular meetings are meant for such decisions, and the format is ideal for resolving these matters.

On the other hand, if what is needed is guidance on how to proceed with a project, or something else short of a formal commitment by the County Court, those may be resolved at either the work sessions or the regular meetings.

Example: *If the County Court needs to consider which of three bidders to award a contract to, and then approve the contract, that is best resolved at a regular meeting. This requires the County Court to make a motion and legally bind the County.*

If the question to the County Court is whether they'd prefer a project be handled within the department or through hiring an outside contractor, that can be resolved at either type of meeting. The commissioners are providing directions to staff, but this does not require any kind of formality or binding commitment made to another person or entity. The contract itself would eventually be approved at a regular meeting.

Where the matter at hand is especially important, such as contracts involving millions of dollars of public funds, the strongly preferred venue is a regular meeting.

Matters requiring public hearings, such as the adoption of ordinances, should be reserved for regular meetings if at all possible. In part, this is to afford the general public with as much prior warning that an ordinance will be considered as reasonably possible under the circumstances.

2. Exceptions

From time to time, issues arise where the normal meeting agenda process is not optimal. The County Court would like to avoid these occurrences. However, if one of these circumstances arise, and there is utility in having a matter on a work session agenda for formal approval by the County Court, please observe the following procedures:

A. Emergencies: For the purpose of this memo, "emergency" refers to a situation which may pose a risk to health, life, or safety, or present some other meaningful harm. The risk in question does not have to be high, necessarily, but it should be something more than merely conjectural. Where delaying a matter until a regular meeting may increase this risk, it is appropriate to ask that the matter be resolved at a work session.

If such an emergency arises, please let the Admin office know that the County Court will be asked to consider a formal decision on an emergency basis. Please also let the Admin office know what the emergency may be – this will help make certain that the matter is given the attention and priority it deserves.

Please note: the mere convenience of County personnel never qualifies as an emergency.

Please also note: if there is a danger to health, life, or safety, the County Court may also be able to schedule a separate, emergency meeting. If your matter may qualify, please speak to your Commissioner liaison to see whether this may be the best solution.

B. Non-emergency, but urgent matters: There may be a variety of important matters for which the County Court may need to act before the next regular meeting can occur. Examples can include: approving letters to the legislature for forthcoming committee meetings; important contracts where the other party demands a decision on an unreasonably short timeframe; or authorizations for hiring of important, vacant positions.

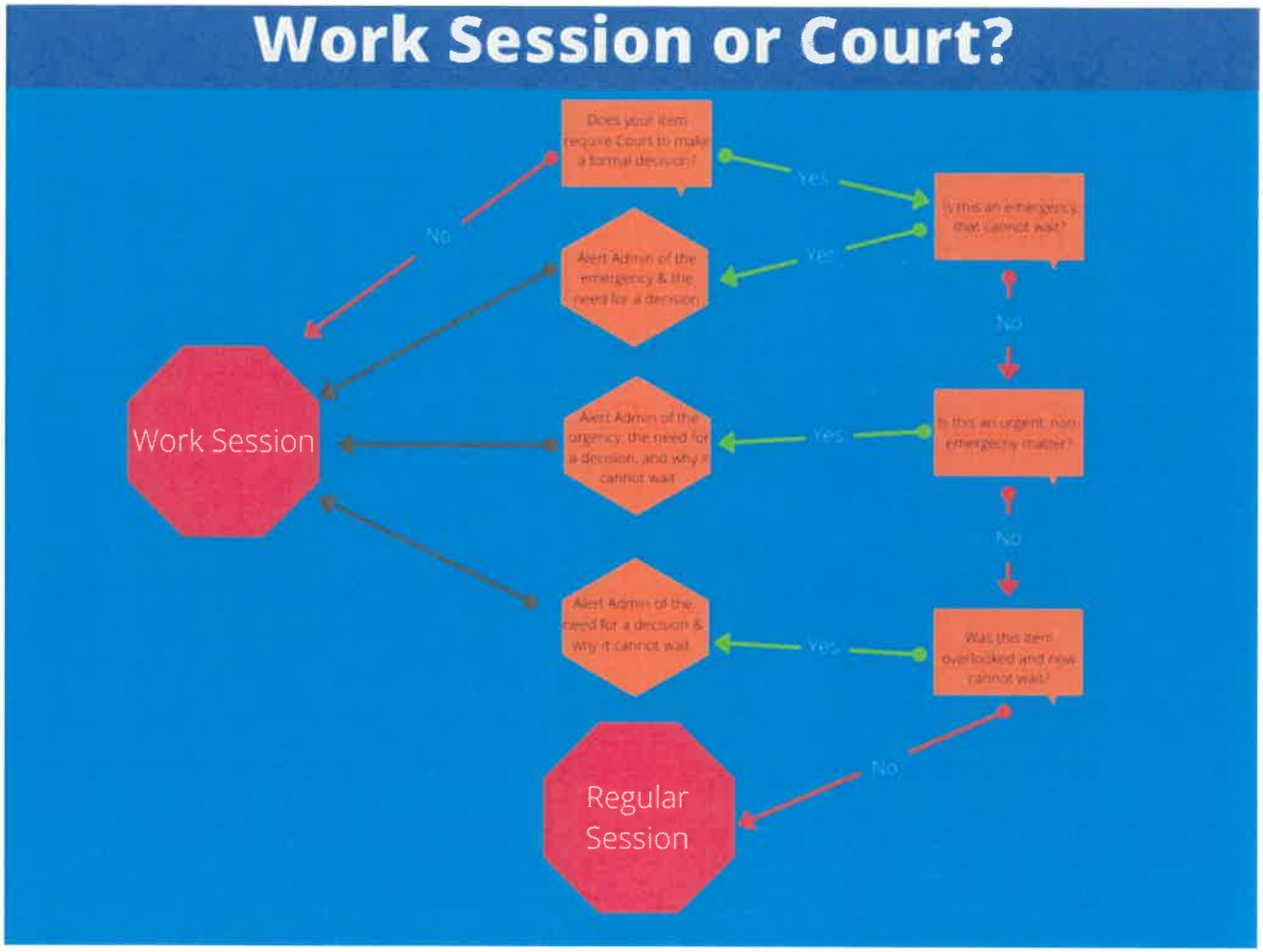
For these matters, please let the Admin office know that the County Court will be asked to consider a formal decision, and why it is not feasible to wait until the next regular meeting.

C. Mistakes and errors: From time to time, all of us will overlook a matter that probably ought to have been on an agenda for a regular meeting. The County Court understands that this will inevitably happen. If possible, the best solution is to wait for another regular meeting to consider the matter.

If, however, under the circumstances that type of delay is not reasonably possible, especially when it will delay or limit the provision of services to the public, the County Court can consider the matter at a work session.

The County Court would like to avoid these "mulligans" as much as possible, and reserve the majority of decisions for regular meetings. When the need arises, please alert the Admin office that the County Court will be asked to make a decision, and then at the meeting itself, explain why the matter was not postponed until the next regular meeting.

3. Flow Chart



For Crook County, Oregon

Seth Crawford, County Judge

Jerry Brummer, County Commissioner

Brian Barney, County Commissioner

Crook County Legal Department

267 NE 2nd St., Suite 200. • Prineville, Oregon 97754 • (541) 416-3919 • FAX (541) 447-6705

MEMO

TO: Crook County Court

FROM: John Eisler, County Counsel's Office

DATE: April 26, 2021

RE: *GIS Professional Services Contract with City of Prineville*
Our File No.: GIS 42

Under the current Professional Services Agreement, the County's GIS Department provides GIS and other IT services to the City in exchange for a set fee. The total amount paid to the County during the last fiscal year was $26,943.68.

The attached Amendment #7 reflects a 3 percent increase for the 2020-21 fiscal year amounting to $27,751.99, and it has been signed by the City of Prineville. GIS Manager Levi Roberts recommends approval.

Please include this item on the County Court Consent Agenda for approval and signatures on Wednesday, May 5, 2021.

AMENDMENT NO. 7 TO PROFESSIONAL SERVICES AGREEMENT
(Crook County GIS Contract)

This Amendment No. 7 is entered into by and between the City of Prineville, hereinafter referred to as "City," and Crook County, hereinafter referred to as "County."

RECITALS

WHEREAS, City and County are parties to that certain Professional Services Agreement (hereinafter "the Agreement") effective July 1, 2014, for the provision of GIS services to City; and

WHEREAS, beginning May 7, 2015, and each successive year thereafter, the parties have entered into Amendments 1 through 6 of the Agreement to extend the services for an additional year and periodically adjust the compensation; and

WHEREAS, the Agreement terminates at 11:59 p.m. on June 30, 2021; and

WHEREAS, the parties wish to extend the duration of the Agreement for an additional year; and

WHEREAS, the parties agree to a three percent (3%) increase for the next fiscal year (July 1, 2021 through June 30, 2022).

AGREEMENT

NOW, THEREFORE, in exchange for the mutual covenants contained below, City and County agree as follows:

1. The recitals listed above are incorporated herein by reference.

2. Paragraph number 1 of the Agreement entitled "Effective Date and Duration" is modified to read as follows:

> Effective Date and Duration: This Agreement is effective July 1, 2014. This Agreement terminates at 11:59 p.m. on June 30, **2022**. The Agreement will be evaluated and may be renewed by mutual consent.

3. Paragraph 2 of the Agreement entitled "Contractor's Services" is modified to read as follows:

> "For the fiscal year 2021-2022, the total amount due for the services under this Agreement is $27,751.99."

///

///

4. This Amendment may be executed in one or more counterparts, including electronically transmitted counterparts, which when taken together shall constitute one in the same instrument. Facsimiles and electronic transmittals of the signed document shall be binding as though they were an original of such signed document.

5. Except as amended by this Amendment No. 7, all other terms of the Agreement and any previous amendments remain in full force and effect.

CITY OF PRINEVILLE

Steve Forrester, City Manager

Date: April 21, 2021

CROOK COUNTY COURT

Seth Crawford, County Judge

Jerry Brummer, County Commissioner

Brian Barney, County Commissioner

Date: _____

Crook County Legal Department

267 NE 2nd St. Ste 200 • Prineville, Oregon 97754 • (541) 416-3919 • FAX (541) 447-6705

MEMO

TO: Crook County Court

FROM: Eric Blaine, County Counsel

DATE: April 26, 2021

RE: Software use agreement with Oregon State University

As part of its relationship with Oregon State University, and to better implement the extension service district's projects, Crook County has executed a number of agreements regarding access to OSU's internal software programs. This includes the "Banner" system of electronic fund management, and a variety of similar programs.

The current iteration of the agreement will continue until June 30, 2021. If approved, the terms of this updated contract will supersede the current agreement, and will continue unless sooner terminated until June 30, 2023.

Under this agreement, up to three County employees working on Extension district projects are granted access to OSU's software systems. The County offers a number of protections to OSU in case the County's employee causes some kind of harm to the University, such as providing an indemnification commitment up to the Oregon tort claims act limits.

This year's iteration of the agreement includes a substantial revision to Paragraph 5, regarding insurance coverages. For the first time, the County must obtain insurance other than commercial general liability. This new insurance includes crime insurance up to $1 million in coverage, and cyber liability insurance up to $2 million in coverage. The latter policy must include a number of specific endorsements, such as media liability (for cases of defamation / libel), Privacy, and Network Security coverage.

Fortunately, we are informed by the County's insurance broker that these new requirements can be met with the County's existing policies.

Please place this memo and the attached document(s) on the Wednesday, May 5, 2021 County Court Agenda as a CONSENT AGENDA ITEM.

INTERGOVERNMENTAL AGREEMENT

THIS INTERGOVERNMENTAL AGREEMENT (the "Agreement") is between CROOK COUNTY ("County"), a political subdivision of the State of Oregon; and OREGON STATE UNIVERSITY for its Extension Service ("OSU").

RECITALS

A. OSU's outreach mission is to engage OSU with people and communities of Oregon to have positive impacts on community livability, economic vitality, natural resources sustainability, and the health and well-being of people and communities.

B. County and OSU entered into an agreement dated April 19, 2013 by last signature under which OSU delivers extension-related services to County residents, and County provides office and technical support for OSU employees who work in extension education programs in County. County also, by separate agreement, provides office space for OSU faculty members and classified staff delivering extension-related services to the County ("OSU Employees").

C. In order for County to provide certain office and technical services to OSU Employees delivering extension-related services to the County, the parties agree that it is mutually beneficial for OSU to provide County employees limited access to certain portions of OSU's central administrative financial database such as Banner FIS and online transaction systems to complete financial transactions and technological systems for collaboration including but not limited to video, file sharing, and productivity software for trainings and supporting educational efforts. County wishes to have such access, and OSU is willing to provide it, according to the terms and conditions of this Agreement, so that each party may continue to have the benefit of the services provided by the other.

THEREFORE, the parties agree as follows:

1. If needed, OSU will authorize three (3) employees, designated, funded, and assigned by County to OSU for the purposes of this Agreement ("Designated Employees"), to have access to security classes or data determined by OSU to be necessary to complete financial transactions and/or provide office and technical support in the following systems or such other systems as OSU may use in the future (collectively, "Secured Systems"):

   a. Financial:
      - OSU's Banner FIS
      - Benny Buy
      - CORE
      - Credit Card Machine systems – Bluefin P2PE and PayConex P2PE
      - OSCAR
      - Touchnet Cashiering for Web Departmental Deposits
      - Travel Reimbursement (TRES) system

b. General Information Technology:
- Adobe Creative Cloud (optional/paid license)
- Box
- Bridge
- Canvas
- Digital Measures
- DocuSign
- Duo
- Google Suite
- Office 365
- Salesforce
- Qualtrics
- Zoom and system required for zoom recording (Kaltura)

c. Website:
- Drupal/OSU-hosted web platforms

By the provision of access to security classes and data, as appropriate, will allow Designated Employees to conduct certain aspects of authorized transactions while not allowing access to restricted data and allow Designated Employees to provide office and technical support and receive necessary OSU training and to support extension educational delivery using OSU's technological systems. Designated Employees will not be authorized to have access to unauthorized Secure Systems. County will require that Designated Employees access only records or data related to, or in support of, OSU Employees who deliver extension-related services to County residents and for whom County provides office and technical support.

2. Upon completion of OSU provided training, OSU will provide Designated Employees access to the Secure Systems to be updated, supplemented or refreshed as OSU determines is appropriate. County will require Designated Employees to adhere to OSU's policies on Acceptable Use of Computing Resources, Acceptable Use of Information, OSU's Information Security Manual, and other current or future OSU policies related to access, use, and security of OSU information and data. County will require Designated Employees to adhere to these policies for the duration of the Designated Employees' access to Secure Systems, and to sign a document indicating each Designated Employee's understanding of such policies and the employee's commitment to adhere to such policies. OSU will provide County with copies of its current policies related to access, use and security of OSU information and data, and will provide County copies of any such policies adopted in the future.

3. County must notify OSU immediately upon receiving information that any Designated Employee may have, or has, accessed any portion of the Secure Systems to which the Designated Employee has not been authorized to access. County must notify OSU immediately upon receiving information that any Designated Employee may have, or has, violated OSU's policies related to access, use, and security of OSU information and data. OSU may refuse continued access at any time to any Designated Employee it determines may have accessed or utilized any information or data or portion of the Secure Systems beyond what is authorized by this Agreement.

4. It is understood that County may receive personnel record information from more than one source, including directly from OSU Employees, in the course of providing office and technical support to OSU. County understands and agrees under ORS 351.065(5), faculty

personnel records are not public records under Oregon Public Records Law. Faculty personnel records may not be disclosed without the faculty member's consent except in the limited circumstances set forth in OSU's Policies and Standards 580-022-0095. Some information from classified and temporary employee personnel records is not required to be disclosed under the Oregon Public Records Law, and access to personnel records of classified employees is also addressed in the OSU/SEIU collective bargaining agreement. County will not release a personnel record of any OSU Employee without first securing, in writing, the concurrence of OSU's Chief Human Resources Officer or designee. As used in this Agreement, "personnel record" means a record containing information kept by OSU or County concerning an employee and furnished by the employee or by others, including, but not limited to, information as to discipline, counseling, membership activity, other behavioral records, professional preparation and experience, professional performance (e.g. assignment and workload, quality of teaching, research and service to the institution), personnel data relating to such matters as promotions, tenure, leaves, retirement credits and the like and professional activities external to the institution, including, but not necessarily limited to, awards, recognition, research activities and travel.

5. County shall obtain and keep in effect during the term of this Agreement, Commercial General Liability Insurance with minimum limits of $2,000,000 per occurrence and $4,000,000 aggregate. OSU and its trustees, officers, employees, and agents shall be included as additional insured in said policy. County shall also obtain and keep in effect during the term of this Agreement, Crime Insurance, including employee dishonesty, forgery or alteration and computer fraud, including endorsement Client's Property (CR 0401 or equivalent), with minimum limits of $1,000,000 per loss. The policy shall include coverage for all directors, officers, agents, and employees of the County. The policy shall include coverage for extended theft or mysterious disappearance, and shall not contain a condition requiring an arrest and conviction. County shall also obtain and keep in effect during the term of this Agreement, cyber liability or privacy and network liability. Coverage limits shall be a minimum of $2,000,000 per claim and $2,000,000 aggregate for cyber liability or privacy and network liability. Such policy shall include coverage for losses arising from the breach of information security or cyber liability (including Technology Errors & Omissions, Network Security and Privacy Liability, Media Liability, Liability arising from the introduction of a computer virus, and Liability arising from theft, dissemination, and/or use of confidential information).

6. Subject to the limitations of the Oregon Tort Claims Act (ORS 30.260 -.300), County shall save, hold harmless and indemnify OSU its trustees, officers, employees, and agents from and against all claims, suits, actions, losses, damages, liabilities, costs and expenses of any nature resulting from, arising out of, or relating to the acts or omissions of County or its officers, employees or agents under this Agreement.

7. County is a subject employer under the Oregon Worker's Compensation Laws and shall either comply with ORS 656.017, which requires employers to provide workers' compensation coverage for all their subject workers, or shall meet the exemption requirement in ORS 656.126.

8. This Agreement shall be governed by and construed in accordance with the laws of the State of Oregon.

9. The term of this Agreement shall begin on the date of last signature and shall end on June 30, 2023. This Agreement may be terminated at any time by mutual agreement of the parties, by either party on 60 days' written notice to the other, or by OSU upon its determination that County has violated any term of this Agreement.

ACKNOWLEDGMENT

The parties to this Agreement, by the signatures below of their authorized representatives, acknowledge having read and understood the Agreement and agree to be bound by its terms and conditions.

BY COUNTY:

Name: Date

Title:

BY OREGON STATE UNIVERSITY:

DocuSigned by:
Anita Azarenko 3/10/2021 | 12:57:05 PST
Date

Anita Azarenko
Interim Vice Provost
OSU Extension and Engagement

DocuSigned by:
3/10/2021 | 12:55:21 PST
Date

Nicole Strong
OSU Regional Director, Central

DocuSigned by:
Mindy Berger 4/6/2021 | 19:21:41 PDT
Date

Contracts Officer
Procurement & Contract Services | PCMM
Mindy Berger

Request to place business before the Crook County Court

Important Note: The County Court is the legislative, policy-setting body of Crook County. Matters which come before the Court should as a general rule be those of general concern to Crook County residents and Crook County. Administrative matters which are the purview of individual departments will be placed on the agenda at the request of the Department Head. By completing this form, you are asking to be placed on the agenda.

Please return this form to Crook County Administration Office via Email: amy.albert@co.crook.or.us; or Mail: 300 NE 3rd St., Prineville OR 97754

Your name: Jonathan Cavazos - Bend Racing Date of Request: April 27, 2021
Email: atr.ops2021@gmail.com Phone: mobile: 541.300.8073
Address (optional): 61445 Barleycorn Lane, Bend OR 97702

1. What is the date of the Court meeting you would like to appear at? TBD

2. Describe the matter to be placed before the Court: Bend Racing is seeking permission for use of the mini-park on May 15th and 16th as a finish line for our adventure race, Expedition Oregon.

3. What action are you requesting that the Court take? We ask the court to allow for the use of the park located on the Courthouse grounds, specifically the portion closest to NE Court St and across from Good Bike beginning at 12:00pm noon on May 15th until 6:00pm on May 16th.

4. What is the cost involved with your request, if applicable? None

5. Please estimate the time required for your presentation.
☐ 5 minutes ☒ 10 minutes ☐ 15 minutes ☐ other _____ minutes

6. Are you (or will you be) represented by legal counsel?
_____ Yes (please name your attorney) _____
__X__ No, I am not currently represented. **(Note: it is your obligation to advise the Court if at any time you retain legal counsel to assist you in this matter.)**

7. If you have a physical disability and require an accommodation, please specify your need:
None

Optional Endorsement:
Signature of County Judge/Commissioner endorsing this request and requesting placement of the agenda: *(A request submitted at the request of a sponsoring commissioner, will be placed on an appropriate agenda. All other matters will be considered for appropriateness for consideration by the full Court in view of the above criteria.)*

_____ _____
Court member signature Date

IN THE COUNTY COURT OF THE STATE OF OREGON
FOR THE COUNTY OF CROOK

IN THE MATTER OF
Accepting revenue, changing related appropriations, line item adjustments and changing expenditure budget appropriations for County Funds for Fiscal Year 2020-21

ORDER #2021-22

WHEREAS, this Order is made in accordance with ORS 294.463 which states transfers of appropriations may be made within fund or between funds, and

WHEREAS, this order is needed to transfer appropriations as described below.

BE IT THEREFORE ORDERED that the Crook County Court hereby adopts this Order for the transfer of appropriations for the purposes shown in the attached "Exhibit A" for the fiscal year ending June 30, 2021.

DATED this 5th day of May 2021.

CROOK COUNTY COURT:

SETH CRAWFORD, County Judge

JERRY BRUMMER, County Commissioner

BRIAN BARNEY, County Commissioner

Exhibit A for Court Order 2021-22

Fund	Department	Original Budget	Change	Revised Budget
General	Legal	432,200	50,000	482,200
General	Administration	604,700	92,000	696,700
General	Non-Departmental	4,316,300	557,967	4,874,267
General	Contingency	2,994,500	(699,967)	2,294,533
		Total	-	

Intrafund appropriation transfer for miscellaneous expenditures

General			Total	699,967
	Description	Change	GL Number	Amount
	Contract Services	Increase	101-2700-520.35-13	50,000
	Postage	Increase	101-2800-520.05-30	12,000
	Office Supplies	Increase	101-2800-520.10-25	5,000
	Registration & Dues	Increase	101-2800-520.45-04	65,000
	Postage Meter Lease	Increase	101-2800-520.55-06	10,000
	Conciliation/Mediation	Increase	101-9900-520.35-09	25,000
	Contract Services - CR Concept	Increase	101-9900-520.35-45	14,000
	Liability Insurance	Increase	101-9900-520.50-05	62,000
	Workers Comp	Increase	101-9900-520.50-11	36,000
	Capital Outlay - New Construction	Increase	101-9900-580.80-54	400,000
	Transfers Out	Increase	101-9900-597-97-00	20,967
	Contingency	Decrease	101-9900-596.96-01	699,967

Fund	Department	Original Budget	Change	Revised Budget
Airport Capital Projects	Airport Capital Projects	-	20,967	20,967
		Total	20,967	

Intrafund appropriation transfer for capital project expenses

Airport Capital Projects			Total	$ 20,967
	Description	Change	GL Number	Amount
	Transfers In	Increase	391-2405-380.00-14	20,908
	Transfers In	Increase	391-2407-380.00-14	59
	Capital Outlay - New Construction	Increase	391-2405-580.80-54	20,908
	Capital Outlay - New Construction	Increase	391-2407-580.80-54	59

Fund	Department	Current Budget	Change	Revised Budget
Sheriff's Office	Sheriff's Office	4,499,600	169,400	4,669,000
Sheriff's Office	Parole and Probation	2,084,300	(119,400)	1,964,900
Sheriff's Office	Contingency	989,300	(50,000)	939,300
		Total	-	

Intrafund appropriation transfer for internal service fees/vehicle purchase

Sheriff's Office			Total	$ 169,400
	Description	Change	GL Number	Amount
	Internal Service Fees	Increase	251-5001-520.66-04	49,200
	Internal Service Fees	Increase	251-5001-520.66-27	21,200
	Internal Service Fees	Increase	251-5001-520.66-28	30,200
	Internal Service Fees	Increase	251-5001-520.66-29	18,800
	Internal Service Fees	Decrease	251-5055-520.66-04	(49,200)
	Internal Service Fees	Decrease	251-5055-520.66-27	(21,200)
	Internal Service Fees	Decrease	251-5055-520.66-28	(30,200)
	Internal Service Fees	Decrease	251-5055-520.66-29	(18,800)
	Capital Outlay - Vehicles	Increase	251-5001-580-80.26	50,000
	Contingency	Decrease	251-5001-569.96-01	(50,000)

IN THE COUNTY COURT OF THE STATE OF OREGON
FOR THE COUNTY OF CROOK

IN THE MATTER OF
INCREASED APPROPRIATIONS **ORDER #2021-23**

WHEREAS, this Order is made in accordance with ORS 294.471 which provides that a governmental entity may make one or more supplemental budgets when:

- An occurrence or condition that was not known at the time the budget was prepared requires a change in financial planning
- Unexpected funds are made available by another unit of federal, state or local government

BE IT THEREFORE ORDERED that the Crook County Court hereby adopts this Order for the purpose of appropriations shown in attached "Exhibit A" for the fiscal year ending June 30, 2021.

DATED this 5th day of May 2021.

CROOK COUNTY COURT:

SETH CRAWFORD, County Judge

JERRY BRUMMER, County Commissioner

BRIAN BARNEY, County Commissioner

Crook County Revised Appropriations Fiscal Year 2020-21

Exhibit A

(Proposed Crook County Supplemental Budget - Court Order #2021-23)

General Fund (101)

Dept.	*Category*	*Increase (Decrease)*	*Explanation*
Legal	Materials & Services	10,950	Federal grant money awarded to pay for COVID related expenses
Administration	Materials & Services	4,088	Federal grant money awarded to pay for COVID related expenses
Non-Dept.	Materials & Services	714,084	Federal grant money awarded to pay for small business assistance
REVISED GENERAL FUND REQUIREMENTS		**16,343,322**	

Community Development Fund (212)

Dept.	*Category*	*Increase (Decrease)*	*Explanation*
Electrical	Personnel	25,000	Additional staffing funded by additional revenues
Electrical	Capital Outlay	30,000	Vehicles purchase with additional revenues
Building	Personnel	75,000	Additional staffing funded by additional revenues
Building	Materials & Services	40,000	Additional revenues appropriated for materials and services expenditures
Building	Capital Outlay	60,000	Vehicles purchase with additional revenues
Administration	Personnel	30,000	Additional staffing funded by additional revenues
Contingency	Contingency	1,510,000	Revenues higher than budgeted amounts
REVISED COMMUNITY DEVELOPMENT FUND REQUIREMENTS		**4,727,000**	

Sheriff's Office (251)

Dept.	*Category*	*Increase (Decrease)*	*Explanation*
Sheriff's Office	Materials & Services	46,000	Minor Equipment purchases funded by additional revenues
Jail	Personnel	200,000	Funds transferred from General Fund appropriated for jail nurse positions
Special Services	Materials & Services	36,200	Federal grant money awarded to pay for COVID related expenses
REVISED SHERIFF'S OFFICE FUND REQUIREMENTS		**12,120,900**	

Health Services (301)

Dept.	*Category*	*Increase (Decrease)*	*Explanation*
Grant Programs - MH Promotions	Personnel	200,000	New revenues appropriated for mental health personnel
REVISED HEALTH SERVICES FUND REQUIREMENTS		**2,976,989**	

Mental Health (311)

Dept.	*Category*	*Increase (Decrease)*	*Explanation*
Mental Health	Materials & Services	600,000	Revenues projected to exceed budgeted amount and will be expended
REVISED MENTAL HEALTH FUND REQUIREMENTS		**3,390,000**	

Crook County Revised Appropriations Fiscal Year 2020-21

Exhibit A

(Proposed Crook County Supplemental Budget - Court Order #2021-23)

Airport Capital Projects Fund (391)

Dept.	*Category*	*Increase (Decrease)*	*Explanation*
Airport Capital Projects	Transfer Out	46,002	Transfer remaining balance on capital project
Airport Capital Projects	Materials & Services	550,000	Appropriation transfer from new construction
Airport Capital Projects	Capital Outlay	(550,000)	Appropriation transfer to materials and services
REVISED AIRPORT CAPITAL PROJECTS FUND REQUIREMENTS		**2,723,002**	

Justice Center Capital Project Fund (392)

Dept.	*Category*	*Increase (Decrease)*	*Explanation*
Justice Center Capital Project	Personnel	12,000	Establish capital project fund for Justice Center
Justice Center Capital Project	Materials & Services	528,000	Establish capital project fund for Justice Center
Justice Center Capital Project	Capital Outlay	460,000	Establish capital project fund for Justice Center
REVISED JUSTICE CENTER CAPITAL PROJECT FUND REQUIREMENTS		**1,000,000**	

Capital Assets Reserve (401)

Dept.	*Category*	*Increase (Decrease)*	*Explanation*
Capital Assets Reserve	Transfers	534,448	Transfer beginning working capital in reserve
Capital Assets Reserve	Reserved	8,753,900	Establish reserve for future expenditures
REVISED CAPITAL ASSET RESERVE EXPENDITURES		**19,664,448**	

Crook County Reserve (401)

Dept.	*Category*	*Increase (Decrease)*	*Explanation*
Crook County Reserve	Transfers	601,630	Transfer out beginning working capital in reserve
REVISED CROOK COUNTY RESERVE REQUIREMENTS		**2,115,230**	

Court Security (401)

Dept.	*Category*	*Increase (Decrease)*	*Explanation*
Court Security	Transfers	391	Transfer out beginning working capital in reserve
REVISED COURT SECURITY REQUIREMENTS		**7,491**	

Law Library (401)

Dept.	*Category*	*Increase (Decrease)*	*Explanation*
Law Library	Transfers	1,932	Transfer out beginning working capital in reserve
REVISED LAW LIBRARY FUND REQUIREMENTS		**53,932**	

Debt Service Fund (502)

Dept.	*Category*	*Increase (Decrease)*	*Explanation*
Debt Service	Principal	45,000	Reclassify appropriation for FF&C Jail bonds debt service from Internal Service Fund
Debt Service	Interest	139,100	Reclassify appropriation for FF&C Jail bonds debt service from Internal Service Fund
REVISED DEBT SERVICE FUND REQUIREMENTS		**184,100**	

Crook County Revised Appropriations Fiscal Year 2020-21

Exhibit A

(Proposed Crook County Supplemental Budget - Court Order #2021-23)

Fairgrounds Fund (701)

Dept.	*Category*	*Increase (Decrease)*	*Explanation*
Fairgrounds	Materials & Services	250,000	Appropriate new grant money and donations
Fairgrounds	Capital Outlay	100,000	Appropriate new grant money and donations
REVISED FAIRGROUNDS FUND REQUIREMENTS		**1,057,100**	

Airport Operations Fund (705)

Dept.	*Category*	*Increase (Decrease)*	*Explanation*
Airport Operations	Materials & Services	268,602	Establish airport operation fund
Airport Operations	Principal	140,000	Establish airport operation fund
Airport Operations	Interest	247,200	Establish airport operation fund
REVISED AIRPORT OPERATIONS FUND REQUIREMENTS		**655,802**	

Weed Fund (708)

Dept.	*Category*	*Increase (Decrease)*	*Explanation*
Weed	Capital Outlay	33,500	Additional BNWC appropriated for vehicle purchase
REVISED WEED FUND REQUIREMENTS		**526,600**	

Facilities Fund (709)

Dept.	*Category*	*Increase (Decrease)*	*Explanation*
Facilities	Materials & Services	66,000	Additional resources underestimated at time of original budget
Facilities	Principal	(185,000)	Transfer appropriations for debt service of Jail & Helibase FF&C bonds
Facilities	Interest	(386,300)	Transfer appropriations for debt service of Jail & Helibase FF&C bonds
Facilities	Contingency	(1,215,300)	Transfer contingency to Capital Assets Reserve
Facilities	Reserved	(8,604,600)	Transfer reserve to Capital Assets Reserve
REVISED FACILITIES FUND REQUIREMENTS		**1,827,900**	

Crook County Legal Department

267 NE 2nd St. Ste 200 • Prineville, Oregon 97754 • (541) 416-3919 • FAX (541) 447-6705

MEMO

TO: Crook County Court

FROM: Eric Blaine, County Counsel

DATE: April 26, 2021

RE: Agreement with Pacificsource for CMHP services
Our File No.: Ct Contracts 254(A)

In addition to the other lengthy contracts the County must review to provide behavioral health services, the County has been asked to approve this new iteration of a contract with Pacificsource Community Solutions. Pacificsource is the regional coordinated care organization (CCO), which manages certain programs for the Oregon Health Authority for the population receiving Medicaid/Oregon Health Plan services.

Under this agreement, Pacificsource passes along obligations which Pacificsource committed to in its contract with the Oregon Health Authority, along with Pacificsource's own policies and requirements, to the three Central Oregon community mental health programs.

Unfortunately, as in prior iterations, this year's agreement reserves for Pacificsource greater authorities and protections than Pacificsource is willing to extend to the three CMHPs.

Please review especially the provisions of page 9, paragraph 2.9(b), and the very similar language on page 71, paragraph 8.12. Under this provision, Pacificsource can decide that *non-material* performance issues need correction. This decision can be made in Pacificsource's "sole discretion." If they decide that these non-material issues need correction, they can require the County to institute a corrective action plan – and if Pacificsource is not satisfied with the outcome, it can terminate the agreement *for material breach*. In that case, the County would presumably suffer all the consequences for breaching the contract, such as paying damages to Pacificsource.

Please note that this paragraph specifically applies to performance deficiencies which "do[ ] not constitute a Material Breach of the terms of this Agreement..." but that if Pacificsource is not satisfied with the correction, then despite the fact that those errors are explicitly described as being not substantial this "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."

For obvious reasons, there is a great deal to be concerned about with this language. It purports to grant Pacificsource abilities to inflict the penalties of material breach onto the County for errors which are explicitly insignificant.

The County has agreed to this language in the past, including in a prior version of this agreement. There will no doubt be pushback from Pacificsource (and possibly OHA) if the County objects to this language. Nevertheless, if there is one provision of this agreement which warrants further negotiations, it is this.

Other important provisions included in this agreement are:

- The agreement is effective retroactive back to April 1, 2021.
- In many places, the agreement incorporates by reference a number of Pacificsource documents and policies (see, for example, page 8, paragraph 2.8), which they post on their website. There is no explicit commitment in this agreement that Pacificsource will not revise those documents without prior notice. This is, we have found, a very common feature of health insurance companies.
- Despite the fact that the CMHPs are intimately tied to public agencies, Pacificsource has included a paragraph stating that during *and after* the duration of the agreement, the agreement's terms and other information is confidential (see page 13, paragraph 2.18). The agreement includes information on rates of payments, formulas for calculations, and descriptions of service requirements which the CMHPs are to provide to Oregon Health Plan patients. This is a major change from the 2019 version, which did not try to keep so much of the agreement secret, and instead explicitly acknowledged that the counties are bound by the Oregon public records law.
- In the event of a future possible lawsuits involving a host of healthcare-related activities and third party suppliers, the agreement requires the County's claims to be subrogated to OHA (see page 14, paragraph 2.23). This would mean that OHA could pursue a lawsuit and incorporate the County's damages into its damage claims. It would not require OHA to remit any damages received back to the County.
- The agreement's duration is 1 year, and unless sooner terminated, renews for additional 1 year terms.
- Pacificsource reserves for itself a variety of reasons why it may terminate, including immediate termination. While this variety is not extended to the counties, at least they too have the ability to terminate for cause.
- Please note that there are multiple termination paragraphs, which are widely spread out within the document. Others are found on page 38, paragraph 10.6; page 37, paragraph 33.3; and page 80, Exhibit I-1, paragraph 3.
- Page 20, paragraph 6.8, reserves for Pacificsource what is called amendment by negative consent. Under this provision, Pacificsource may issue a proposed amendment. If one of the counties does not object within 60 days, that failure

to object is considered acceptance. This abrogates the normal rule that silence is not acceptance of any contract offer. Although we do not often see such a provision, so long as the parties agree to allow negative consent, the parties are free to include it into their contracts.

- Attachment C (page 28) includes an expansive new training requirement for staff. This is tied to OHA's efforts to promote equality of outcomes for healthcare services.
- The indemnification paragraphs on page 36 afford greater protections to Pacificsource than it does for the counties.
- OHA (which is not a party to this agreement) and Pacificsource may terminate this agreement if there is a force majeure event that they determine will prevent successful performance of the agreement. See page 37, paragraph 33.3. There is no ability for the County to terminate in a force majeure event.
- The County is obligated to provide, on a monthly basis, a list of personnel who provide services. See page 44, paragraph 6.
- Exhibit G, starting on page 46, describes what elements must be included in the "2021 Risk Model," a document on which Pacificsource and the three county mental health programs are meant to collaborate in drafting.
- The final attachment, Exhibit I-1, states that it may be separately terminated by the parties, without altering the effectiveness of the underlying agreement. See page 80, paragraph 3.
- The agreement incorporates the terms of the 290-page OHA/Pacificsource contract.[1] See page 33, paragraph 23.1. One of the terms of those allows OHA to direct Pacificsource to suspend payments to the counties if OHA deems there to be a creditable allegation[2] of fraud, waste, or abuse under existing federal regulations. Note that this authority does not apply only if there has been a finding of actual wrongdoing – the mere existing of an allegation which OHA deems credible is sufficient.

Please place this memo and the attached document(s) on the Wednesday, May 5, 2021 County Court Agenda as a DISCUSSION ITEM.

[1] We have not been provided with Exhibit C to that agreement, which discusses the consideration paid to Pacificsource with public funds. I am not certain why this is being kept secret.
[2] See OHA / Pacificsource agreement, page 155, paragraph g.

PacificSource
Community Solutions

PARTICIPATING PROVIDER AGREEMENT

This Participating Provider Agreement is made and entered into as of this **1st** day of **April, 2021** ("Effective Date") by and between **PacificSource Community Solutions**, an Oregon non-profit corporation ("Health Plan") and **Central Oregon Community Mental Health Programs** ("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 Oregon Health Plan. "Oregon Health Plan" ("OHP") means the Oregon Medicaid Demonstration Project, as established by chapter 815, Oregon Laws 1993, and later amended.

1.18 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.

1.19 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.

1.20 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.

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

(i) 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.

(j) 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.

(k) 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.

(l) 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 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 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.

2.20 Appointment Availability. Provider shall report appointment availability using a format consistent with OHA requirements and provided by Health Plan. Provider shall also provide or otherwise make available timely treatment to each Member in

accord with the CCO Contract, and if not addressed in the CCO Contract, OAR 410-141-3515 as summarized below and as later amended or superseded:

(a) Emergency Care – immediately

(b) Emergency Dental Services – seen or treated within 24 hours

(c) Urgent Physical Health Services – within 72 hours

(d) Well Care – within four weeks or within the community standard

(e) Non-Urgent Behavioral Health Treatment – within two weeks of Member request

(f) Routine Oral Health Care – eight weeks

2.21 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.

2.22 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 H. 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 or Provider 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 Mutual Non-Disparagement. Provider and CMHP agree that neither party will make any defamatory, slanderous, or intentionally inaccurate statements about the other for the purpose of interfering with the relationship between the Member and the Provider or the Member and the Health Plan. Nothing in this section is intended to interfere with 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 or Health

Plan'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.

6.5 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.

6.6 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.

6.7 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.

6.8 Amendments. Health Plan may amend this Agreement by providing prior written notice to Provider, such notice shall include a statement of the reason for the proposed amendment and citation to any relevant state or federal law or regulation authorizing the change. Failure of Provider to object in writing to any such proposed amendment within sixty (60) 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.

6.9 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.

6.10 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.

6.11 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.

6.12 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.

6.13 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.

6.14 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

6.15 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.

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

6.17 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 entered into this Agreement as of the date first set forth above.

PACIFICSOURCE COMMUNITY SOLUTIONS

By: _____
PETER MCGARRY

Title: VP PROVIDER NETWORK

Date: _____

Address: PO Box 7469
Bend, OR 97701

DESCHUTES COUNTY HEALTH SERVICES

By: _____
ANTHONY DeBONE, CHAIR

_____
PHIL CHANG, VICE CHAIR

_____
PATTY ADAIR, COMMISSIONER

Title: BOARD OF DESCHUTES COUNTY COMMISSIONERS

Date: _____

Address: 2577 NE Courtney Drive
Bend, OR 97701

JEFFERSON COUNTY HEALTH SERVICES BOARD OF COUNTY COMMISIONERS

By:_____

Name: WAYNE FORDING

Title: COMMISSIONER

Date:_____

JEFFERSON COUNTY HEALTH SERVICES BOARD OF COUNTY COMMISSIONERS

By:_____

Name: KELLY SIMMELINK

Title: COMMISSIONER

Date:_____

JEFFERSON COUNTY HEALTH SERVICES BOARD OF COUNTY COMMISSIONERS

By:_____

Name: MAE HUSTON

Title: COMMISSIONER

Date:_____

PACIFICSOURCE COMMUNITY SOLUTIONS

By:_____

Name: PETER MCGARRY

Title: VP PROVIDER NETWORK

Date:_____

CROOK COUNTY HEALTH SERVICES
BOARD OF COUNTY COMMISIONERS

By:_____

Name: SETH CRAWFORD

Title: COUNTY JUDGE

Date:_____

CROOK COUNTY HEALTH SERVICES
BOARD OF COUNTY COMMISIONERS

By:_____

Name: JERRY BRUMMER

Title: COUNTY COMMISSIONER

Date:_____

CROOK COUNTY HEALTH SERVICES
BOARD OF COUNTY COMMISIONERS

By:_____

Name: BRIAN BARNEY

Title: COUNTY COMMISSIONER

Date:_____

PACIFICSOURCE COMMUNITY SOLUTIONS

By:_____

Name: PETER MCGARRY

Title: VP PROVIDER NETWORK

Date:_____

ATTACHMENT B

Central Oregon Community Mental Health Programs
04/01/2021

Credentialing

1. 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. 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

Central Oregon Community Mental Health Programs
04/01/2021

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

Central Oregon Community Mental Health Programs
04/01/2021

Oregon Health Plan (Oregon Health Authority) Contract Language

In the event that any provision contained in this Attachment conflicts or creates an ambiguity with a provision in this Agreement, this Attachment's provisions will prevail. Capitalized terms not otherwise defined herein shall have the meaning set forth in the OHA Contract and/or the Cover All Kids 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, the Oregon Health Authority's ("OHA") instructions applicable to this Agreement, and 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 ("Health Plan"). [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 Health Plan's contracts with OHA to administer the Oregon Health Plan (the "CCO Contract"), and the Cover All Kids program (the "CAK 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 Health Plan 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 Health Plan 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 Health Plan on that evaluation. Provider further understands that OHA has the right to receive all such evaluations. [Exhibit B, Part 4, Section 11(a)]

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

6.0 Provider understands that Health Plan 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 Health Plan with information to confirm such checks. [Exhibit B, Part 4, Section 11(a)]

7.0 Provider understands that Health Plan may not Delegate certain work under the OHA Contracts and that this Agreement does not terminate Health Plan's legal responsibility to OHA for the timely and effective performance of Health Plan'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 Health Plan of the OHA Contracts. Further, Provider understands that Health Plan is solely responsible to OHA for any corrective action plans, sanctions, or the like, and that Health Plan 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 Health Plan must provide OHA with a list of subcontractors and activities required to be performed under such subcontracts, including this Agreement, and shall include: (i) the legal name of Provider, (ii) the scope of work being subcontracted, (iii) copies of the ownership disclosure form, if applicable, (iv) information about any ownership stake between Health Plan and Provider, if any, and (v) an attestation from Health Plan 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 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 Health Plan. [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 Health Plan's written procedures for its Grievance and Appeal System, and agrees to comply with the requirements therein. [Exhibit B, Part 4, Section 11(a); Exhibit I, Section 1(b)(1)]

13.0 Provider understands and agrees that Health Plan shall monitor and may audit Provider's performance on an ongoing basis, including performance, deficiencies, and areas for improvement.

14.0 Provider agrees that it shall be placed under a corrective action plan ("CAP") if Health Plan identifies any deficiencies or areas for improvement in the ongoing monitoring or annual report and that Health Plan 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 Health Plan has the right to take remedial action, pass down or impose Sanctions, and that Health Plan intends this Agreement to reflect that Health Plan 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 Health Plan 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 Health Plan determine Provider has breached the terms of this Agreement; provided, however, that Health Plan 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 Health Plan 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, and sub-regulatory guidance and contract provisions. [Exhibit B, Part 4, Section 11(b)]

20.0 Provider expressly agrees that 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 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 Provider agrees to adopt and comply with Health Plan'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 Health Plan any provider and Member Fraud, Waste, or Abuse ("FWA"), which Health Plan 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 CCO Contract, Sections 10-17 of the CAK Contract, 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. If Provider is a provider, this requirements includes offering hours of operation that are not less than the hours of operation offered to commercial PacificSource members. [Exhibit B, Part 4, Section 11(b)]

25.0 Provider agrees to report promptly to Health Plan 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 Health Plan TPL Guidebook or upon Health Plan or OHA request, with all Third-Party Liability eligibility information and any other information requested by Health Plan 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 16(e)(1); Part 8, Section 17(o)(5)]

27.0 Provider agrees to document, maintain, and provide to Health Plan 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 Health Plan upon request. [Exhibit B, Part 4, Section 11(c)]

28.0 Provider understands and agrees that if Health Plan 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 Health Plan 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 Health Plan's Service Authorization Handbook. [Exhibit B, Part 2, Section 3(a)]

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

30.3 For preventive Covered Services, report all such services provided to Members to Health Plan and such services are subject to Health Plan'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 Health Plan, its staff, Vendor, Participating Providers, or OHA, threat the Member. [Exhibit B, Part 3, Section 2(o)]

30.5 Adhere to Health Plan'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(i)]

30.7 Ensure that all Traditional Health Workers undergo and meet the requirements for, and pass the required background check, as described in OAR 410-180-0326. [Exhibit B, part 4, Section 5(a)(5)]

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 Health Plan provided the services directly, and comply with Oregon House Bill 2398 (2017) by (i) waiting ninety (90) days after submitting the claim before assigning a claim to a collection agency or other similar entity for the purpose of recovering fees from the patient, (ii) querying OHA's database to confirm eligibility for medical assistance, and (iii) assigning any outstanding claims to a collection agency or other similar entity for the purpose of recovering fees from a patient only if, at the time of service, the patient was not eligible for medical assistance. [Exhibit B, Part 8, Section 4(f)]

30.9 If Health Plan's OHA Contracts is 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), 16 (Information Privacy/Security/Access), 19 (Assignment of Contract, Successors in Interest), 20 (Subcontracts), 25 (Survival), 31 (Equal Access), 32 (Media Disclosure), and 33 (Mandatory Reporting of Abuse) of Exhibit D of the OHA Contracts, as if fully set forth herein, for the benefit of both OHA and Health Plan. [Exhibit D, Section 20]

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

30.12 Exhibit F of the OHA Contracts, as if fully set forth herein, for the benefit of both OHA and Health Plan. [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 Health Plan to fulfill its reporting obligations to OHA. [Exhibit I, Section 1(e)(10), Section 2(d), Section 10]

30.14 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 2(a)]

30.15 Provide all required information to Health Plan necessary for Health Plan to submit an annual Behavioral Health report to OHA. [Exhibit M, Section 21]

30.16 Take any Health Plan required training or otherwise provide training within Provider's operations regarding recovery principles, motivational interviewing, integration, and Foundations of Trauma Informed Care (https://traumainformedoregon.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 22]

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 can receive access to 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 Health Plan, or its subcontractor, for Health Plan 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 Health Plan 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 Health Plan'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 Health Plan Members, Provider shall defend, save, hold harmless and indemnify Health Plan, 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 Health Plan by OHA related to a breach of this Agreement by Provider; (ii) for Liquidated Damages assessed against Health Plan 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 Health Plan 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 Health Plan 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 Health Plan 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 17]

10.4 *No Third Party Beneficiaries.* Health Plan 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 Health Plan 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.

10.5 *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.

10.6 *Termination; Revocation of Delegated Activities.* Notwithstanding any other provision in this Agreement, Health Plan 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.

10.7 *Subcontractor/FDR Manual.* Vendor shall comply with the due dates and requirements in Health Plan'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.

11.0 Differences Between the CCO Contract and the CAK Contract. There are a few language differences between the CCO Contract and the CAK Contract. 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 both populations, both contracts will apply, as applicable, to the situation depending on what work and what population is involved. Provider may request a comparison document of the two contracts from Health Plan, which was prepared by OHA.

ATTACHMENT E

Central Oregon Community Mental Health Programs

04/01/2021

Behavioral Health and Community Mental Health Programs

1.0 Certificate of Approval

Provider is contracted to perform work that may encompass services covered under one or more Certificates of Approval (COA) issued by the Oregon Health Authority. Provider certifies that Provider has active COAs as indicated by "X" in the left column of the table below. Provider will supply copies of COAs to Health Plan prior to execution of this Agreement and upon request. Provider will notify Health Plan immediately upon any change to the information listed below.

Active	Type of Certificate of Approval
	Community Mental Health Program
	Residential Substance Use Disorder & Problem Gambling Treatment
	Outpatient Behavioral Health Services
	Intensive Treatment Services for Children and Adolescents
	Outpatient Opioid Treatment Programs
	N/A - Provider does not hold and is not required to hold any Certificates of Approval.

2.0 Community Mental Health Program Responsibilities

If Provider is a Community Mental Health Program designated by its Local Mental Health Authority (LMHA), then Provider is contracted to perform the following services required of an LMHA by OHA and per Health Plan's CCO contract with OHA:

a. Management of children and adults at risk of entering or who are transitioning from the Oregon State Hospital or from residential care;

b. Care coordination of residential services and supports for adults and children;

c. Management of the mental health crisis system including mobile crisis 24 hours a day, every day;

d. Community-based specialized services:

   i. Supported Employment and Education

   ii. Early Psychosis including Early Assessment and Support Alliance

   iii. Assertive Community Treatment (ACT)

   iv. Evidence-based intensive services for adult Members who refuse ACT services

v. Intensive case management and home-based services for children

e. Management of specialized services to reduce recidivism of individuals with mental illness in the criminal justice system.

f. LMHA-designated Community Mental Health Programs shall track all grievances communicated to Provider by a Member or Member representative and report to Health Plan.

g. LMHA-designated Community Mental Health Programs shall provide care coordination services to Members to assist their receipt of Covered Services or long term care services outside of those available from Provider. Services provided may include establishing pre-commitment service linkages, advocating for treatment needs, and providing assistance in obtaining entitlements based on mental or emotional disability. Provider shall arrange and coordinate with all provider types and social service agencies, regardless of inclusion with the status as Covered Services, on an ongoing basis. Such coordination shall include without limitation all Agency for People with Disabilities facilities in the Service Area, justice system, Department of Human Services, acute care facilities, outpatient behavioral health clinics, primary care clinics, physical health specialty clinics, substance abuse facilities, and any Health Plan Provider.

h. LMHA-designated Community Mental Health Programs shall facilitate ongoing communication and collaboration, including facilitating communication between the family, natural supports, community resources, and involved providers and agencies; organizing, facilitating and participating in team meetings; and providing for continuity of care by creating linkages to and managing transitions between levels of care and transitions for young adults in transition to adult services.

3.0 Specific Responsibilities

a. Delegated CCO Duties, subject to satisfactory completion of prior Health Plan audit of activity, or if not, completion of pre-delegation audit:

i. Credentialing of Clinical Professionals

ii. Intensive Care Coordination

b. Evidence-based dyadic treatment for children

c. Outpatient Mental Health for Children and Adults, including (a) psychiatric consultation by physicians or nurse practitioners to community based providers, and (b) psychiatric care provided to clients under an access process not universally contingent on enrollment in psychotherapy services.

d. Wraparound Services for Children and Youth

e. Intensive Outpatient Services and Supports for Children and Youth

f. Peer delivered services

g. CANS assessments

h. Outpatient Substance Use Disorder Services

i. Outpatient Substance Use Disorder Services (ASAM Level 1)

ii. Intensive Outpatient Substance Use Disorder Services (ASAM Level 2.1)

iii. Including services targeting the needs of the following special populations (for example: Adolescents; Women and women's specific issues; Ethnically and racially diverse group and environments that are culturally responsive and linguistically relevant; Intravenous drug users; Individuals involved with the criminal justice system; Individuals with co-occurring disorders; and Parents accessing residential treatment with any accompanying dependent children).

4.0 Performance Responsibilities

a. Provider shall meet the following conditions in accord with the CCO Contract, meaning the Sample Oregon Health Plan Health Plan Services Coordinated Care Organization Contract and any subsequent revisions or replacement contracts, which can be accessed on the OHA website or from Health Plan upon request:

i. Assertive Community Treatment (ACT) services shall be provided in accord with CCO Contract Exhibit M, Section 8 and any subsequent amendments.

ii. Provider shall report ACT program data as detailed in the CCO Contract Exhibit M, Section 8 in a form and on a schedule to be specified by Health Plan.

iii. Crisis Services, including respite and mobile crisis team, shall be provided 24 hours a day every day and shall be provided in accord with CCO Contract Exhibit M, Section 10.

iv. Children's Wraparound Services shall be implemented in accord with CCO Contract, Exhibit M, Section 19, including the documents referenced in the section, and the relevant Health Plan policy in effect.

v. Children's Wraparound Services shall be assessed using the OHA-designated evaluation tools, including WFI-EZ and TOM 2.0, and shall report results using the designated Oregon State data collection system.

vi. Child and Adolescent Needs and Strengths screening shall be conducted with all Members under care with Provider in the situations specified in the CCO Contract, Exhibit M, Section 19 and shall be recorded in the designated Oregon State data collection system.

b. Intensive Care Coordination shall be provided as detailed in CCO Contract Exhibit M, Section 11 and subject to satisfactory completion of pre-delegation audit by Health Plan as a condition of payment for these services.

c. Provider shall provide services to established Members who are admitted to Acute Inpatient Psychiatric Facilities including a follow-up visit within seven (7) days of discharge consistent with Exhibit M, Section 17 of the CCO Contract.

d. Provider shall use health information technology to identify Members with more than two (2) emergency department visits in six (6) months and provide follow-up within three (3) days after the triggering visit.

5.0 Special Provisions

a. All services and supports shall be rendered in the most integrated community-based settings possible, consistent with the Member's choice, so as to minimize the use of institutional care. All services and supports shall be in accordance with all applicable state and federal requirements.

b. Provider shall ensure health equity (including interpretation and cultural competence) and elimination of avoidable gaps in health care quality and outcomes, as measured by gender identity, race, ethnicity, language, disability, sexual orientation, age, mental health and addictions status, geography, and other cultural and socioeconomic factors, consistent with OAR 410-141-3710.

Exhibit F
Administrative Responsibilities
Community Mental Health Programs of Central Oregon
Effective 04/01/2021

CMHPs shall provide the following administrative services, which are delegated by Health Plan, and for which CMHPs shall develop policies and procedures related to these delegated responsibilities and provide such copies to Health Plan.

1. **Encounter Data**

   CMHPs shall electronically submit accurate and complete encounter data for services provided to Members. CMHPs shall submit encounter data on a regular basis and shall, in all cases, submit encounter data no later than one hundred twenty (120) days after the date of service provided to Member and will have one hundred twenty (120) days following the date of the encounter submission to make any necessary changes.

2. **Critical Incidents**

   CMHPs shall follow Health Plan's relevant written policies and procedures related to critical incidents and shall use Health Plan's reporting template for critical incidents that require Health Plan notification within two (2) business days. CMHPs shall submit a Critical Incident Log Sheet to Health Plan on a quarterly basis.

3. **Measures and Outcomes Tracking System Reporting (MOTS)**

   CMHPs shall ensure that all its providers of Behavioral Health services, including those for DUII and methadone programs, enroll their Members in the Measures and Outcomes Tracking System, formerly known as CPMS, as specified at http://www.oregon.gov/oha/amh/mots/Pages/index.aspx.

4. **Third Party Recovery**

   Medicaid is the payor of last resort to be accessed after any other coverage in effect, including Medicare, has been billed for Covered Services. CMHPs shall bill and collect from liable third party resources prior to using capitated Medicaid funds to cover the cost of services. CMHPs shall maintain records in such a manner as to ensure that all moneys collected from third party resources on behalf of Members are identified and reported to Health Plan.

5. **Staff Credentials**

   CMHPs shall provide to Health Plan the necessary information for its employees and independent contracted staff to be credentialed with Health Plan, consistent with Health Plan policies and requirements. The Health Plan Credentialing Department will put a priority on the processing of credentialing applications received from the CMHPs. In the event the

credentialing process is delayed through no fault of the CMHPs, and results in substantial uncompensated services, the CMHPs and the Health Plan will determine the appropriate restitution.

6. Provider Roster

CMHPs shall document and submit a Provider Roster ("Roster") to Health Plan monthly to the following email address: credentialing@pacificsource.com. The Roster will identify all staff and independent contractors who provide outpatient services to Members under this Agreement. Roster shall document the academic degree, license, certification, and/or qualifications of each employee and subcontractor providing services under this Agreement. If the employee or subcontractor is not required to be licensed or certified, Roster will indicate a designation as CADC, QMHA, QMHP, Mental Health Intern, Interns or PSS. Roster shall also reflect, where applicable, the academic specialty or other applicable evidence of specialized qualifications of such individuals. The roster will be updated every thirty (30) days.

7. Behavioral Health MLR Reporting

Health Plan and CMHPs agree to report monthly and annually on the financial performance of the Behavioral Health services covered under this Agreement using the Exhibit L Financial Supplemental SE spreadsheet that can be accessed at the following link: https://www.oregon.gov/oha/HSD/OHP/Pages/CCO-Contract-Forms.aspx
Tabs L-6 and L8 of the spreadsheet are to be completed and uploaded annually to the PacificSource ShareFiles site in the MLR Expense folder by March 30th, 2021.

The Health Plan agrees to provide claims data file for fee-for-service and sub-capitated claims services to CMHPs. Data files will be provided by Health Plan through secure methods within thirty-one (31) days after the calendar month ends. Health Plan shall provide a financial reconciliation report for the calendar year ending December 31st within a reasonable time after year-end.

i. Health Plan and CMHPs agree that the year-end financial reconciliation report is necessary for CMHPs to verify the amount and accuracy of the use of the holdback. The year-end financial reconciliation report shall contain the following data elements: a unique member identifier number internally generated by Health Plan; Age Range 17 and under and 18 and over; Date of Service; Date of Payment; Primary Diagnoses; Service ID Code; Service ID Description; Billed Amount; Paid Amount; Units; and Provider Name. Health Plan and CMHPs agree that the data elements listed above constitute the minimum necessary required to enable CMHPs to verify the holdback and that none of the data to be provided is subject to the limitations of 45 CFR Part 2. Health Plan and CMHPs further agree that the identity of any Member cannot be determined with reasonable accuracy either directly or by reference to other information.

ii. CMHPs agree to provide quarterly and annual reports as applicable on (a) OHP encounters/billing, (b) OHP non-encounterable services, (c) system supports, (d) OHP funding utilization percentage, and (e) non-OHP funds, "non-billable" services, & system

supports Quarterly reports shall be submitted within sixty (60) days of the end of the quarter. Annual report for the time period ending December 31st shall be submitted within ninety (90) days of the end of the calendar year. Data shall be reported both in aggregate by CMHPs and also reported broken out by the following service elements:

1. Crisis Services

2. Services to Adults

3. Services to Children and Youth (without Wraparound)

4. Wraparound Services

5. SUD Only Treatment Services

6. Other

8. Exclusion Checks

CMHPs will perform criminal background checks for employees at the time of hire. CMHPs will perform a review of the Office of Inspector (OIG) and the General Services Administration (GSA) exclusion lists for employees at the time of hire and monthly thereafter. If an individual is found to be on the referenced lists, the CMHPs will immediately remove the individual from any work related directly or indirectly to all Federal health care programs, in accordance with 42 CFR 438.602, 42 CFR 410.610 and 42 CFR 455.436.

8.1. **Reporting.** CMHPs shall provide results of the monthly checks to Health Plan on a quarterly basis and as requested. The results summary shall provide the number of individuals checked and the number of individuals that were found and not found on the lists. Reporting is due no later than twenty (20) business days following the end of the prior month.

9. Integrity Audit Reporting

CMHPs will report quarterly data integrity audit percentages to Health Plan using an audit tool approved by the PacificSource Quality Department.

EXHIBIT G – OHP COMPENSATION

1.0 RISK MODEL

The 2021 Risk model agreed upon by Health Plan and Central Oregon Community Mental Health Programs (CMHPs) shall contain the following:

(A) A construct involving two (2) main Coordinated Care Organization (CCO) territories (Central Oregon CCO and Columbia Gorge CCO) and settlements within each CCO for OHP Members, as well as the potential for settlement impacts for CMHPs should CMHPs provide services to OHP Members from the Lane, Marion/Polk or Portland area CCOs. In the Central Oregon CCO, the single community budget settlement shall be for those OHP Members who are assigned to primary care providers of SCMG and COIPA. In the Central Oregon CCO, there are some OHP Members who are assigned to primary care providers other than SCMG and COIPA, for whom there is no settlement as of the Effective Date of this amendment.

(B) A Hospital Capitation Payment to St. Charles Health System (SCHS) for certain hospital services in the Central Oregon CCO as a component of the single community budget settlement, and for which there is a Hospital Capitation Withhold (HCW) which shall be settled for SCMG, COIPA, SCHS and the Community Mental Health Programs (CMHPs) in Central Oregon and distributed independently of any single community Health Care Budget (HCB) settlement determining a surplus or deficit.

(C) The non-applicability of payment to hospital based providers affiliated with Provider, and for whom payment shall be based on a separate facility agreement with SCHS.

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

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

(F) Capitated and fee-for-service payment to physical to the CMHPs for services provided as detailed in Exhibit 3. Fee-for-service payments shall have a Claims Risk Withhold.

(G) Patient-Centered Primary Care Home (PCPCH) and Behavioral Health Integration (BHI) per member per month payments for which Provider can qualify.

(H) Payment allocations for (B), (C), (D), (E), (F) and (G) above, and a single community settlement for all overall health care expenses, as compared to a single community HCB to determine Claims Risk Withhold and Surplus returns for SCMG, COIPA, other providers, hospital providers, Community Mental Health Programs (CMHPs) and Health Plan.

(I) A single-community risk model which features Revenue and Expenses for physical health, behavioral health/Chemical Dependency (CD), Alcohol/Drug – Residential, and Behavioral Health – Residential services under OHP, paid by the state of Oregon to Health Plan as a global capitation payment, and not otherwise designated as revenue contingent on innovation grants, and the exclusion of Revenue and Expenses in the following OHP categories:

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

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

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

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

2.0 CAPITATION

2.1 Hospital Capitation Rate (HCR) paid to SCHS: The HCR shall be **$105.50** per member, per month (PMPM), which has been calculated for the membership in the month of November 2020, and will fluctuate with membership fluctuations in each Rate Category, consistent with the revenue components listed in Section 1,H above. The HCR and the resulting Hospital Capitation Payment to SCHS may vary as Estimated Earned Net Premium Revenue payments from the state of Oregon to Health Plan increase or decrease, and is a weighted average of the following Central Oregon CCO membership in various benefit categories (which will change each month with membership) and PMPM Capitation Rates specific to each Rate Category as indicated below:

Rate Category	PMPM Capitation Rate	Nov. 2020 Membership
Aid to Blind/Disabled & OAA with Medicare	$19.75	3,474
Aid to Blind/Disabled & OAA w/o Medicare	$382.70	2,132
CAF Children	$27.14	820
ACA Ages 19-44	$92.59	15,411
ACA Ages 45-54	$182.82	4,089
ACA Ages 55-64	$205.24	4,183
PLM, TANF and CHIP Children age < 1	$417.99	1,217
PLM, TANF and CHIP Children age 1-5	$25.87	6,333
PLM, TANF and CHIP Children age 6-18	$26.60	14,990
PLM Adults (includes pregnancy)	$642.73	420
TANF (Adults only)	$167.40	5,042
BCCP	$425.34	18

Weighted Average	**$105.50**
Total Average Membership, Central Oregon CCO	**58,128**

2.2 **Hospital Capitation Withhold (HCW):** The Hospital Capitation Payment will have a twelve percent (12%) Hospital Capitation Withhold.

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

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

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

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

Both parties acknowledge the need for, and agree to participate in a series of meetings in 2021 to review specific service utilization within hospital capitation, with enough time to conclude information review that informs SCMG , COIPA, SCHS, CMHP and Health Plan board or other organizational decision-making on the continuation of hospital capitation in 2022.

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

- Professional Services billed by SCHS professional and hospital-based providers and billed on a CMS 1500 form or UB-04 or other form, which, unless covered under a separate agreement, will be reimbursed at current OHP rates and eight percent (8%) claims risk withhold.

- Services provided by and billed under St. Charles Medical Group and St. Charles Family Care.

- Services provided by and billed under Sageview Behavioral Health.

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

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

2.5 Primary Care Capitation Rate. For services provided by SCMG and COIPA who is providing certain primary care services for SCMG and COIPA assigned OHP Members, reimbursement will be made on or around the 15th of every month, and shall be:

Primary Care Capitation Rate **$25.46 per member per month**

This Primary Care Capitation rate will be **$25.46** per member per month for SCMG and COIPA Federally Qualified Health Centers or Rural Health Centers, upon identification as such by Health Plan and SCMG and COIPA .

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

Rate Category	PCP Adjustment Factor
Aid to Blind/Disabled & OAA with Medicare	0.3475
Aid to Blind/Disabled & OAA without Medicare	2.2243
CAF Children	1.0280
ACA Ages 19-44	0.9551
ACA Ages 45-54	1.4266
ACA Ages 55-64	1.4900
PLM, TANF and CHIP Children age < 1	1.5641
PLM, TANF and CHIP Children age 1-5	0.9435
PLM, TANF and CHIP Children age 6-18	0.6882
Poverty Level Medical Adults (includes pregnancy)	0.9551
TANF (Adults only)	0.9551
BCCP	0.9551

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

2.6 Covered Services Paid By Primary Care Capitation Rate

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

Services	CPT Codes
Office Visits	99201-99205, 99211-99215, 99241-99245
Home Services	99341-99345, 99347-99350
Other Office Services	92551, 92552, 93000, 93005, 93010, 93790, 95115-95134, 99000-99002, 99050, 99051, 99053, 99056, 99058, 99070, 99080, 99366-99368, 99429, 99441-99443

Minor Surgical Services	10060, 10061, 10080, 10120, 10140, 10160, 11720, 11721, 11740, 16000, 16020, 17110, 17111, 20550, 20600, 20605, 20610, 30300, 36415, 45300, 45303, 46600, 46604, 51701, 54050, 54055, 54056, 56501, 65205, 65220, 69200, 69210

3.0 COMPENSATION – ALL OTHER PROFESSIONAL SERVICES

For non-capitated primary care services and all specialty/ancillary services provided to OHP Members irrespective of primary care provider assignment, SCMG and COIPA shall be compensated based on Resource Based Relative Value Scale ("RBRVS") conversion factors or a percentage of the current OHP fee schedule. Most services will be less an established Claims Risk Withhold. On an annual basis, this Claims Risk Withhold will be returned in whole, in part, or not returned, based upon (a) the comparison of paid and incurred claims expenses and other costs, to an established single community HCB in Sections 7.5 and 7.6 of this Exhibit B as well as the performance of quality metrics in Section 7.6, or (b) per the contract of the OHP Member's primary care provider, if other than SCMG or COIPA .

3.1 CCO Fee For Service

SERVICE/PROCEDURE	MAXIMUM ALLOWABLE	Risk Withhold
Services listed in the CMS Physicians Fee Schedule: OHA GPCI Adjusted RVUs for services listed in the July 2019 Medicare Physician Fee Schedule	$39.58 conversion factor[1, 2, 3]	8%
Labor and Delivery: CPT Codes 59400-59622	$60.22 conversion factor[1, 2, 3]	8%
Laboratory: Services classified by CMS using OHP Medical-Dental Fee Schedule	100% of OHP Allowable[1, 3]	8%
Anesthesia: Services classified in the American Society of Anesthesiologists Relative Value Guide	$36.54 per unit ASA Conversion Factor[4]	8%
Durable Medical Equipment, Prosthetics, Orthotics and Supplies: Services listed in the OHP Medical-Dental Fee Schedule	100% of OHP Allowable[1, 3]	8%

Injectables, Vaccines, Immunizations: Services listed in the OHP Medical-Dental Fee Schedule	108% of OHP Allowable[1, 3]	8%
Services and procedures without an OHP Allowable	30% of Billed Charges	8%

Note: Payment will be based upon the lesser of the billed amount or Health Plan negotiated rates in effect at the time the service or supplies are rendered or provided as specified above.
1. Updates to the schedules noted above shall be updated in accordance to OHP.
2. Facility and non-facility RVUs shall be used and determined by the setting in which the service occurs.
3. Health Plan will reimburse based on the rates published as of the date of adjudication
4. ASA Basic Unit Value and annual updates as defined by the American Society of Anesthesiologists Relative Value Guide. Time units shall be based on fifteen (15) minute increments.

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

SCMG and COIPA primary care provider groups are eligible for the following PCPCH and BHI payment amounts based on meeting the specified criteria and levels for each program which shall be an expense toward the single community HCB.

Eligibility for payments will be at sole discretion of Health Plan as determined by OHA criteria and on-site and/or other evaluations and shall be determined for each physical clinic site, as defined in Oregon's PCPCH program. Providers are eligible for the Base Rate or the Program Participation Rate, but not both.

PCPCH Payments	Base Rate without Program Participation	Program Participation Rate includes Base Rate
Tier 1 PCPCH	$0.50 PMPM	NA
Tier 2 PCPCH	$1.01 PMPM	NA
Tier 3 PCPCH	$2.01 PMPM	$ 6.00 PMPM
Tier 4 PCPCH	$3.02 PMPM	$ 9.00 PMPM
Tier 5 PCPCH	$4.02 PMPM	$12.00 PMPM

Behavioral Health Integration Payments	
Level 1 BHI	**NA**
Level 2 BHI	**$3.00 PMPM**

3.2.1 PCPCH Payment Criteria. Base Rate payments are earned based on active PCPCH Tier level as reported by the Oregon Health Authority. Providers must submit an attestation citing clinic location to initiate payments.

Program Participation payment levels are based on a clinic site's PCPCH Tier status, as awarded by the OHA, and approval from Health Plan based on providing high value elements including the following as detailed in the PCPCH Program Description and PCPCH Program Attestation Form:

a) Minimum staffing standards
b) Scheduled, paid team time for panel management such as huddles, registry review, and quality improvement meetings – minimum 4 hours per month.
c) Documentation of chronic disease management processes and workflows addressing, including at a minimum, asthma, diabetes, hypertension, congestive heart failure or coronary artery disease, SBIRT and any other condition identified by OHA.
d) Same-day or unscheduled acute care services available within the same zip code as the clinic that are available for SCMG and COIPA patients during the hours of 5pm-7pm every non-holiday weeknight and 9am-2pm on at least one weekend day.
e) Performance Measures reporting and targets. For initial calendar year of participation, reporting alone shall be adequate. For future years, improvement in the measures will be a requirement of continued participation with specific targets to be determined:

    - CAHPS survey, all results from an all-payer or OHP-only sample of at least 100 patients annually
    - Quarterly reporting on Health Information Exchange functions currently in use by clinic site and referral status (closed, incomplete, open, cancelled) of e-referrals using regional Health Information Exchange

Tier status and update to payment may be requested by SCMG and COIPA no more than twice per calendar year and will be made by Health Plan upon receipt of complete attestation and measures reporting. Payment per-member per-month to be made at least quarterly. Calculation of payment will be based on OHP Members assigned to primary care providers of SCMG and COIPA working at the clinic site, which shall be solely determined by Health Plan.

Eligibility may be retracted by Health Plan and payment discontinued if its evaluation determined that previously approved clinic site has not maintained program requirements.

3.2.2 Integrated Behavioral Health – Primary Care. Providers may qualify for the additional amounts for Behavioral Health Integration for services provided in compliance with the minimum standards as defined by the Integrated Behavioral Health Alliance (IBHA) or as amended from time to time. Detailed description and requirements are provided in the Health Plan *Integrated Behavioral Health Program Description* and the *IBHA Assessment Tool for Integrated Behavioral Health Services*. Requirements for continued eligibility for payment include but are not limited to:

BHI Level 1: Access to -AG modifier for enhanced FFS payments
Providers may bill for services provided by behavioral health professionals working in an integrated setting. Claims must be submitted with the modifier -AG to designate and allow tracking of integrated services.

BHI Level 2: Access to -AG modifier for enhanced FFS payments + PMPM
At a minimum, the clinic must meet all BHI Level 1 requirements plus all the following:

1. Certified as PCPCH Tier 3, 4, or 5 by the Oregon Health Authority;
2. Meet IBHA Standard 2.7 as defined in the *Assessment Tool for Integrated Behavioral Health Services;*
3. Meets a minimum staffing ratio of 1.0 FTE Behavioral Health Clinician per 6 FTE PCPs per clinic site (IBHA Standard 1) or 1.0 FTE Behavioral Health Clinician per 9,000 active clinic patients;
4. Demonstrates maintaining a minimum population reach percentage, as defined in the specifications in the *Integrated Behavioral Health Program Description*. The clinic must submit year-to-date data quarterly to Health Plan. During first year of eligibility, the clinic must meet a minimum of 5% population reach and 10% thereafter;
5. Adherence to all Level 2 program requirements as outlined in the *Integrated Behavioral Health Program Description*;
6. Participation in annual verification site visits; and
7. Participation by BHC(s) and other appropriate primary care providers and clinic staff in regional technical assistance activities offered by Health Plan such as community of practice meetings, group learning opportunities, onsite technical assistance, and other collaborative events.

Billing for behavioral health clinician services are to be consistent with Health Plan policies, including "–AG modifier" and "Incident To" methodologies.

Fee-for-service reimbursement using the –AG modifiers per stated requirements for certain codes approved by Health Plan are as follows (and shall be charged to the single community HCB):

SERVICE/PROCEDURE	MAXIMUM ALLOWABLE
Services listed on the OHP Behavioral Health Fee Schedule:	
MD, DO	150% of OHP Allowable[1, 2]
PMHNP, PhD, PSYD	100% of OHP Allowable[1, 2]
LCSW, LPC, LMFT	100% of OHP Allowable[1, 2]

Note: Payment will be based upon the lesser of the billed amount or Health Plan negotiated rates in effect at the time the service or supplies are rendered or provided as specified above.
1. Updates to the schedules noted above shall be updated in accordance to OHP.
2. Health Plan will reimburse based on the rates published as of the date of adjudication.

Eligibility may be retracted by Health Plan and payment discontinued if its evaluation determines that the previously approved clinic site has not maintained fidelity to IBHA model or program requirements.

3.2.3 Integrated Behavioral Health – Other Settings. Services provided in clinics that are not primary care clinics may be reimbursed for providing behavioral health services. Payment will be made on a fee-for-service payment for encounterable services as detailed below and charged to the single community HCB. Fee-for-service payments are limited to the codes listed by Health Plan as approved for use within this payment model.

SERVICE/PROCEDURE	MAXIMUM ALLOWABLE
Services listed on the OHP Behavioral Health Fee Schedule:	
MD, DO	150% of OHP Allowable[1, 2]
PMHNP, PhD, PSYD	100% of OHP Allowable[1, 2]
LCSW, LPC, LMFT	100% of OHP Allowable[1, 2]

Note: Payment will be based upon the lesser of the billed amount or Health Plan negotiated rates in effect at the time the service or supplies are rendered or provided as specified above.
1. Updates to the schedules noted above shall be updated in accordance to OHP.
2. Health Plan will reimburse based on the rates published as of the date of adjudication

3.2.4 Specialty Behavioral Health. Services defined as Specialty Behavioral Health services are provided by mental health professionals on an episodic, repetitive basis for mental health and substance use disorder conditions that cannot can be handled by a behavioral health provider providing services integrated with a primary care team. Payment for these services requires execution by provider of a separate contract with Health Plan as a panel behavioral health provider per Exhibit B-1.

3.2.5 Providers agree to engage in meetings every two (2) months with COIPA, SCMG, SCHS, Health Plan, CMHPs and others to review behavioral health and substance abuse expense trends and solutions to address costs in this sector.

3.3 Claims Risk Withhold.

Payments to SCMG and COIPA for professional services shall have eight percent (8%) of the Allowed Compensation, as set forth in Sections 3.1, 3.2.2 and 3.2.3 above, withheld as a Claims Risk Withhold, and in the event of a Deficit in the single community HCB, used to offset such Deficit.

4.0 ALTERNATIVE PAYMENT MODELS

4.1 Pediatric Hospitalist Program.

SCHS shall be paid one dollar and twenty-five cents ($1.25) per OHP Member, per month, for OHP Members assigned to SCMG and COIPA's primary care providers in Central Oregon, to support a Pediatric Hospitalist Program (the "Program"). This amount will be an expense against the single community HCB, and with payment by Health Plan for any OHP Members assigned to other primary care providers in Central Oregon, to support the costs of the Program. Program revenue and costs, including FTE costs, will be reported showing any deficit/surplus. SCHS will provide, no less than quarterly, the accounting for the Program revenue and costs as described above to Health Plan.

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

SCMG and COIPA shall be paid three dollars and thirty cents ($3.30) per OHP Member, per month, for OHP Members assigned to SCMG and COIPA . This amount will be an expense against the single community HCB, and will be allocated for SCMG and COIPA's best efforts toward:

- Provider supporting access reporting, enhanced access (outside regular business hours), and improvements in response to the results of the Central Oregon Access Study.

- Provider supporting quality improvements activities (including Quality Incentive Metric (QIM) performance), including QIM and eCQM reporting and data submission, and

- Provider supporting programs pertaining to PCPCH certification (including attainment of and maintenance of Tier 5 certification).

SCMG and COIPA shall report to Health Plan on a quarterly basis how the funds were disbursed. This reporting will be used to determine the impact of the funds. Health Plan will also use this reporting to support its communication, health advocacy and negotiation with OHA.

5.0 PREMIUM ALLOCATION.

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

5.1 Definitions. Estimated Earned Net Premium Revenue. Estimated Earned Net Premium Revenue shall consist of those global capitation payments (including adjustments and reconciliations with the state of Oregon) received by Health Plan from the State of Oregon for OHP Members assigned to SCMG and COIPA's primary care providers in the Central Oregon CCO for health services under OHP, less premium allocations and/or payments for services in Section 1,H, which include: Dental Care premium allocation paid to DCOs, Non-Emergent Medical Transportation premium allocation paid to NEMT vendors, payments to COHC per the agreement with the COHC including any maximum payment limitation for 2021, taxes, adjustments, premium transfers, innovation grant revenue, OHA-required Hepatitis C reconciliations with OHA as necessary, and any portion of QIM bonus or QIM withhold retained per agreement with the COHC.

5.2 Allocation of Estimated Earned Net Premium Revenue.
After the application of any QDP/GME/MCO/Provider taxes, ACA taxes, OHA-required qualified directed pass-through payments, Health Plan Income Taxes for Medicaid, a payment to fund the COHC in the amount of one percent (1%) of gross premium (not counting pass-through funds) including any maximum payment limitation for 2021 of $2,500,000 per the agreement of the COHC, premium transfers for Dual Eligible Medicare premium and excluding: Dental Care premium allocation paid to DCOs, Non-Emergent Medical Transportation premium allocation paid to NEMT vendors, innovation grant revenue, OHA-required Hepatitis C reconciliation adjustments with the OHA/state of Oregon as necessary, and QIM withhold retained per agreement with the COHC, the remaining Estimated Earned Net Premium Revenue will be allocated as follows:

5.2.1 Administration. Eight and seventy hundredths percent (8.70%) of the remaining Estimated Earned Net Premium Revenue shall be allocated to Health Plan for administration.

5.2.2 Amounts Allocated to the single community HCB. Ninety-one and thirty hundredths percent (91.30%) of the remaining Estimated Earned Net Premium Revenue shall be allocated to the single community HCB.

6.0 ALLOCATIONS AND DISBURSEMENT

6.1 Computation of Budget Expenses.

For all OHP Members assigned to primary care providers of SCMG and COIPA, all claims expenses (including Claims Risk Withhold), PMPM fees (including credentialing and any CPC+ expenses), reinsurance/stop loss premium expenses (less recoveries), Pharmacy Expenses (less rebates), Hospital Capitation Payments (including HCW), PCP Capitation Expense, subrogation adjustments, premium/MCO taxes, coinsurance expenses, out-of-area expenses, ancillary expenses, behavioral health/Chemical Dependency (CD) expenses paid to CMHPs, SCHS and other panel providers, Alcohol/Drug Residential expenses, Behavioral Health – Residential expenses, Health Services and other expenses iterated in the Joint Management Agreement (JMA) and JMA budget between Health Plan and the COHC, and any 2021 Bridges Health cost allocations shall be charged to the single community HCB based on the day services were actually rendered with the exception of Late Claims, as defined in Section 6.2 below, which shall be charged to the next year's applicable budget.

6.2 Disposition of Late Claims.

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

7.0 SETTLEMENT PARAMETERS.

7.1 Settlement Parameters for OHP Members

The following settlement parameters for this Section 7 pertain for OHP Members assigned to SCMG and COIPA's primary care providers. It shall not include the experience of OHP Members assigned to primary care providers of entities other than SCMG and COIPA. CMHPs understand and agree to be subject to the settlement terms of non-provider agreements when CMHPs provide services for OHP Members assigned to non-SCMG and non-COIPA entities.

7.2 Time Period.

Annual Claims Risk Withhold and HCW settlement reports will occur for the 2021 calendar year four months (120 days) after the close of the contract period ending December 31st. Any charges/credits to the applicable budgets that have occurred since the settlement of the previous contract period are accounted for in the settlement of the current period.

7.3 Claims Risk Withhold Settlement Summary.

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

7.4 Settlement Sequence – First Settlement (Hospital Capitation Withhold)

There will be two (2) independent settlements. The first settlement will be the settlement of the HCW for OHP Members assigned to primary care providers of SCMG and COIPA.

7.4.1 Allocation. The HCW of twelve percent (12%) of the Hospital Capitation Payment as allocated for the members assigned to primary care providers of SCMG and COIPA will be held by Health Plan until the time of settlement of the single community HCB. This HCW as allocated for the OHP Members assigned to SCMG and COIPA can be earned by the following parties in the following approximate proportions, with the SCMG and COIPA shares adjusted for actual OHP Members assigned to their primary care providers for 2021:

- **SCMG** **12.25% of HCW**
- **COIPA** **36.75% of HCW**
- **SCHS** **49.00% of HCW**
- **CMHPs** **2.00% of HCW**

7.4.2 HCW settlement for CMHPs. HCW for OHP Members assigned to primary care providers of SCMG and COIPA will be awarded upon the meeting of performance goals in utilization and process areas as follows and as updated for automatic changes in calendar years or Oregon Health Authority benchmark changes, or as changed via amendment:

1. Follow-Up After Hospitalization for Mental Illness within 7 days (2021 OHA Aligned Measure #37)	
Weighting	20%
Performance Monitoring	PacificSource reporting using PacificSource data, administrative claims only
Final Result[1]	PacificSource data, administrative claims only
Target	Greater than or equal to (>=) 90.8%
Population	Central Oregon CCO Members
Measure Specification	OHA Current Specification: Follow-Up after Hospitalization for Mental Illness
Denominator	Per OHA Current Specification. Deviation from Specification: Discharges from Sage View only are included in the Denominator.
Numerator	Per OHA Current Specification
2. Prenatal & Postpartum Care - Postpartum Care (2021 OHA Aligned Measure #15)	
Weighting	20%
Performance Monitoring	PacificSource reporting using PacificSource data, administrative claims only
Final Result[1]	OHA 2021 Final Hybrid QIM Results
Target	Greater than or equal to (>=) 80.1%
Population	Central Oregon CCO Members
Measure Specification	OHA (QIM) Current Specification: Prenatal and Postpartum Care
Denominator	Per OHA (QIM) Current Specification
Numerator	Per OHA (QIM) Current Specification
3. Follow-up After ED Visit for Mental Illness within 30 days (2021 OHA Aligned Measure #38)	
Weighting	20%
Performance Monitoring	PacificSource reporting using PacificSource data, administrative claims only
Final Result[1]	PacificSource data, administrative claims only
Target	Greater than or equal to (>=) 74.1%
Population	Central Oregon CCO Members
Measure Specification	HEDIS Current Specification: Follow-Up After Emergency Department Visit for Mental Illness
Denominator	Per HEDIS Current Specification
Numerator	Per HEDIS Current Specification
4. Follow-up After ED Visit for Alcohol or Other Drug Abuse or Dependence within 30 days (2021 OHA Aligned Measure #39)	
Weighting	20%
Performance Monitoring	PacificSource reporting using PacificSource data, administrative claims only
Final Result[1]	PacificSource data, administrative claims only
Target	Greater than or equal to (>=) 35.5%
Population	Central Oregon CCO Members
Measure Specification	HEDIS Current Specification: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence
Denominator	Per HEDIS Current Specification
Numerator	Per HEDIS Current Specification

5. Standardized Healthcare-Associated Infection Ratio (2021 OHA Aligned Measure #45)	
Weighting	*Clostridium difficile* (C. Diff) intestinal infections – 6% Central Line-Associated Bloodstream Infections (CLABSI) – 4% Catheter-associated Urinary Tract Infections (CAUTI) – 6% Methicillin-resistant *Staphylococcus Aureus* (MRSA) blood infections – 4%
Performance Monitoring	St Charles Hospital
Final Result[2]	St Charles Hospital[2] **Final result is subject to review and audit by PacificSource*
Target	Final rate is not statistically significantly worse than the expected rate. Each rate is measured and scored separately.
Population	All St Charles Hospital hospitalizations (entire St Charles Hospital population regardless of location)
Measure Specification	N/A – Measure Steward: NHSN, NCQA
Denominator	As per NHSN Specification for hospitals
Numerator	As per NHSN Specification for hospitals

[1]Final contract performance results will be available after final QIM results are delivered from OHA and will be included in the final reconciliation risk reports.

[2]St Charles Hospital must provide final results for all four (4) Standardized Healthcare-Associated Infection Ratio (SIR) measures by 11:59 PST on March 31, 2022 to be eligible for payout. Performance reporting for each of the four (4) SIR measures must include:

- Standardized Infection Ratio (SIR)
- Count of Observed Infections
- Expected (Predicted) Infections
- 95% Confidence Interval for SIR (low and high)

Final results must be sent via email to the following recipients:
RiskReportAnalytics@pacificsource.com
Alison.Little@pacificsource.com
Peter.McGarry@pacificsource.com

Health Plan and CMHPs acknowledge that the COVID-19 pandemic in 2021 may have an impact on the achievability of these metrics, and that Health Plan, SCMG , SCHS, COIPA and CMHPs may meet to discuss appropriate and mutually agreeable adjustments from time to time as a result. Any modifications made shall be consistent with known state or federal rules, requirements and guidance.

7.4.3 HCW for SCHS. HCW return for SCHS, per Section 7.4.1 above, shall be determined based on the terms in the agreement between Health Plan and SCHS.

7.4.4 Overage Settlement. In addition to the HCW settlement in Section 7.4.1, there shall be a second settlement intended to share any overage of any Hospital Capitation Payment to SCHS beyond the fee-for-service equivalent of 100% of OHP Allowable Amounts (consistent with all OHA/state of Oregon rules/calculations of DRG inclusion/exclusions and other terms used to calculate revenue paid to Health Plan as CCO). The report to be used as a basis for this calculation is Health Plan's Central Oregon CCO "St. Charles OHP Hospital Capitation Report" (see attached example, concluding this amendment).

Health Plan will calculate: (A) The amount of payment which would have been received by SCHS based on its Hospital Capitation Payment, less HCW, plus its full portion/49% share of HCW calculated as if full performance metrics in Section 7.4.2 are achieved, even if they are not.

Health Plan will calculate: (B) The amount of payment SCHS would have received in lieu of Hospital Capitation Payment, had it been paid 100% of OHP Allowable Amounts (consistent with all OHA/state of Oregon rules/calculations of DRG inclusion/exclusions and other terms used to calculate revenue paid to Health Plan as CCO).

If A is greater than B, Health Plan will calculate this differential and distribute it in the following manner, with the Provider and COIPA shares adjusted for actual OHP Members assigned to primary care providers between the two (2) entities for 2021:

- **SCMG** **12.25% of HCW**
- **COIPA** **36.75% of HCW**
- **SCHS** **49.00% of HCW**
- **CMHPs** **2.00% of HCW**

If B is greater than A, there will be no additional overage calculation or settlement impact on the HCW settlement.

If there is insufficient amounts in the settlement calculation in Section 7.4.1 to cover the amounts owed by SCHS to other entities in Section 7.4.4., it is understood that SCHS will make such payment to other entities directly.

7.4.5 Unearned HCW

Any HCW not paid to CMHPs shall be considered Unearned HCW. Unearned HCW shall be allocated in the following manner:

1st Used to offset any Deficits for the single community HCB settlement, after the application of Claims Risk Withhold.

2nd Any remaining Unearned HCW will contribute to Health Plan margin, consistent with limitations in the Joint Management Agreement (JMA) between Health Plan and the COHC.

3rd Any remaining Unearned HCW will be treated as shared savings under the terms of the JMA.

7.5 Settlement Sequence – Second Settlement (Health Care Budget, (HCB))

After completion of the HCW settlement, the single community HCB shall be settled.

7.5.1 The single community HCB is established for the following health care expenses for those OHP Members assigned to primary care providers of SCMG and COIPA: Hospital Capitation Payments (including HCW) consistent with Section 2, PCP Capitation payments consistent with Section 2, claims expenses for professional services including those established by the reimbursement terms in Section 3 (including Claims Risk Withhold), Pharmacy expenses (less rebates), out-of-area expenses, and other provider PMPM fees per Sections 4, or other PMPM expenses, ancillary services, reinsurance premium (less recovery amounts), premium/MCO taxes, coinsurance expense, subrogation adjustments, behavioral health/Chemical Dependency (CD) expenses paid to CMHPs, SCHS and other panel providers, Alcohol/Drug – Residential expenses, Behavioral Health-residential expenses, and Health Services and other expenses iterated in the JMA and JMA budget between Health Plan and COHC, as well as any Bridges Health cost allocations for 2021.

7.6 Budget Surplus or Deficit.

For the contract period for the experience of OHP Members assigned to SCMG and COIPA, the single community HCB will be compared to actual expenses incurred per Section 7.5 to determine whether a Surplus or Deficit exists.

7.6.1 Surplus. If the total value of total covered claims and expenses, including

HCW and Claims Risk Withhold, is less than the HCB, a Surplus exists. Surplus will be limited to seventy percent (70%) of the Surplus amount for 2021, with any increase beyond this amount contingent on a review of the one percent (1%) of gross premium allocated to COHC for community reinvestment. In the event of a Surplus, Claims Risk Withhold and Surplus share amounts will be returned/paid based on the below contingencies by approximately August 30 following the contract year. Any unknown final OHA determinations of QIM revenue or any OHA decisions on any revenue reductions will be applied and adjusted for the following contract year. Surplus amounts may be offset against amounts owed to Health Plan, if amounts owed are not otherwise paid to Health Plan. Surplus payment amounts are additionally determined according to the following:

Surplus and Claims Risk Withhold Contingent on Quality. As a one-time reduction from prior levels for 2021 to help providers due to the Covid-19 pandemic, fifty percent (50%) of the Surplus from the single community HCB will be contingent on quality performance. Twenty-five percent (25%) of any accumulated Claims Risk Withhold return will be contingent on quality performance.

Approximately twelve and six-tenths percent (12.6%) of the Surplus will be earnable by SCMG , forty-two and a four-tenths percent (42.4%) of the Surplus will be earnable by COIPA, forty percent (40%) of the Surplus will be earnable by SCHS, and five percent (5%) of the Surplus will be earnable by the CMHPs and allocated proportionate to CMHP-represented county populations of OHP Members. SCMG and COIPA shares shall be adjusted for actual OHP Members assigned to primary care providers between the two (2) entities for 2021. Fifty percent (50%) of the Surplus and twenty-five percent (25%) of the Claims Risk Withhold are paid contingent on the performance of the below metrics, the majority of which are established and measured by the state of Oregon for the entire Central Oregon CCO, which are based on the final target setting for the Central Oregon CCO by OHA, and will be awarded based on such state of Oregon measurement and state of Oregon final payment. Any other metric not established by the state of Oregon is an alternative metric and indicated with a (*), and is designed and measured by Health Plan. The following metrics will be used:

1. Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life (2021 OHA Aligned Measure #3)	
Weighting	20%
Performance Monitoring	PacificSource reporting using PacificSource data, administrative claims only
Final Result	OHA 2021 Final QIM Results
Target	OHA Central OR CCO 2021 QIM Measure Target
Population	Central Oregon CCO Members
Measure Specification	OHA (QIM) Current Specification: **Child and Adolescent Well-Care Visits**
Denominator	Per OHA (QIM) Current Specification
Numerator	Per OHA (QIM) Current Specification
2. Immunizations for Adolescents (Combo 2) (2021 OHA Aligned Measure #2)	
Weighting	20%
Performance Monitoring	PacificSource reporting using PacificSource data, administrative claims only
Final Result	OHA 2021 Final QIM Results
Target	OHA Central OR CCO 2021 QIM Measure Target
Population	Central Oregon CCO Members
Measure Specification	OHA (QIM) Current Specification: **Immunizations for Adolescents**
Denominator	Per OHA (QIM) Current Specification
Numerator	Per OHA (QIM) Current Specification
3. Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (2021 OHA Aligned Measure #31)	
Weighting	20%
Performance Monitoring	PacificSource reporting using Marion-Polk CCO clinic submitted electronic health record data[1]
Final Result	OHA 2021 Final QIM Results
Target	OHA Central OR CCO 2021 QIM Measure Target
Population	Central Oregon CCO Members
Measure Specification	OHA (QIM) Current Specification: **Diabetes: HbA1c Poor Control**
Denominator	Per OHA (QIM) Current Specification
Numerator	Per OHA (QIM) Current Specification
4. Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (2021 OHA Aligned Measure #37)	
Weighting	20%
Performance Monitoring	PacificSource reporting using PacificSource data, administrative claims only
Final Result	OHA 2021 Final QIM Results
Targets	OHA Central OR CCO 2021 QIM Measure Targets - This is a two-part measure with a target for Initiation and a separate target for Engagement. Both targets must be met.
Population	Central Oregon CCO Members
Measure Specification	OHA (QIM) Current Specification: **Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment**
Denominator	Per OHA (QIM) Current Specification
Numerator	Per OHA (QIM) Current Specification

5. Behavioral Health Integration for Members with Diabetes and an HbA1c >=9	
Weighting	20%
Performance Monitoring	PacificSource monitoring, using data submitted at least quarterly by participating clinics[2]
Final Result	PacificSource, using final report data submitted by participating clinics
Target	Aggregated total of all clinics greater than or equal to (>=) 35%. Exception: Madras Medical Group and Bend Memorial Clinic will be reporting only.
Population	Central Oregon CCO Members receiving care at Mosaic, St Charles Medical Group, or La Pine Community Health Center, Madras Medical Group and Bend Memorial clinics.
Measure Specification	N/A – Measure Steward: PacificSource
Denominator	All Members with a diagnosis of Diabetes Mellitus who had at least one HbA1c >9 during the 2021 calendar year.
Numerator	Members in denominator who received at least one visit with an integrated Behavioral Health Consultant (BHC) in the 2021 calendar year.

[1] Participating organizations must report monthly data to PacificSource by the 20th of each month. To be eligible for payout, final 2021 eCQM data submissions must be received by PacificSource from participating clinics no later than 11:59 PM PST on January 20, 2022. All submissions are subject to audit by PacificSource for accuracy.

All reporting data submissions must be sent via previously agreed upon SFTP or via email to the following recipient: ecqmreporting@pacificsource.com

[2] To be eligible for payout, participating clinics are required to submit reporting at a minimum of once per quarter using the "Behavioral Health Integration for Members with Diabetes and Depression Report Template" provided by PacificSource. While payout is based only on Behavioral Health Integration for Members with Diabetes and an HbA1c >9, participating clinics must still complete the "Behavioral Health Integration for Members with Diabetes and Depression Report Template" in entirety. Quarterly reports are due:

- April 30, 2021 (time period 1/1/2021 – 3/31/2021)
- July 31, 2021 (time period 1/1/2021 – 6/30/2021)
- October 31, 2021 (time period 1/1/2021 – 9/30/2021)
- January 31, 2022 (time period 1/1/2021 – 12/31/2021) *Final Report

Final results must be sent via email to the following recipients:
RiskReportAnalytics@pacificsource.com
Alison.Little@pacificsource.com
Peter.McGarry@pacificsource.com

Health Plan and Providers acknowledge that the COVID-19 pandemic in 2021 may have an impact on the achievability of these metrics, and that Health Plan, SCMG , COIPA, SCHS and CMHPs may meet to discuss appropriate and mutually agreeable adjustments from time to time as a result. Any modifications made shall be consistent with known state or federal rules, requirements and guidance.

7.6.2 Unearned Surplus and Claims Risk Withhold Contingent On Quality

Any Unearned Quality Surplus and Claims Risk Withhold shall be allocated in the following manner:

1st Used to contribute to Health Plan margin, consistent with the limitation in the Joint Management Agreement (JMA) between Health Plan and the COHC.

2nd Any remaining Unearned Surplus Contingent On Quality will be treated as shared savings under the terms of the JMA.

7.6.3 Deficit. If the value of total covered claims and expenses, including HCW and accumulated Claims Risk Withhold from all providers, is more than the single community HCB, a Deficit exists, and any and all Claims Risk Withhold will be used to satisfy the Deficit at an equal percentage for all providers. If any Claims Risk Withhold remains upon the Deficit being reduced to zero dollars ($0.00), it will be returned to CMHPs with twenty-five percent (25%) of any distributable Claim Risk Withhold return contingent on the performance of the quality metrics in Section 7.6.

Once all CMHPs Claims Risk Withhold is used to offset a Deficit, the only remaining dollars from CMHPs to offset any remaining Deficit shall come from unearned HCW.

7.6.4 Limited Liability for CMHPs . If the Deficit of the HCB exceeds the amount of total Claims Risk Withhold, no further amounts will be payable from CMHPs to reduce the Deficit beyond any unearned amounts.

8.0 GENERAL PROVISIONS.

8.1 Defined Terms.

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

8.2 Precedence.

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

8.3 Health Plan Reporting

Health Plan shall provide to CMHPs accurate and timely reports to assist CMHPs in monitoring utilization, financial, and quality-related data. A schedule of reports and the frequency with which these reports are to be provided is listed below.

Existing Claims Risk Withhold Settlement Report, Central Oregon CCO	Monthly in 2021 and through March of 2022, by the end of the month, starting six (6) months after the beginning of the contract start date.

8.4 Health Services Understanding

Health Plan and SCMG and COIPA signed a separate Letter of Understanding in July of 2015 which detailed the appropriate allocation of certain health care expenses as being part of the single community HCB per Section 6.1 and 7.5. Consistent with that understanding Health Plan (a) has entered into a contract with OHA whereby Health Plan has agreed to manage programs to optimize cost, quality and experience of care for OHP Members, (b) is mandated to operate such programs with auditable reporting requirements, (c) has signed an agreement with OHA (consistent with OHA rules and regulations) which stipulates such program expenses are accounted for outside Health Plan administrative/general expenses and are part of health care expenses which are part of the single community HCB in this Agreement, and (d) calculates a PMPM expense as a percentage of the CCO global budget, to pay for such Health Services programs.

8.5 Requirements

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

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

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

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

8.6 Oregon Health Plan/OHA Capitation Administration Regulations

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

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

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

8.7 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 2021 (a) primary care provider capitation rate, (b) professional conversion factors, or (c) hospital capitation rates agreed to in this 2021 amendment to the Agreement, Health Plan will notify CMHPs of such inconsistency in writing, and both parties will enter into a renegotiation of 2021 reimbursement rates in order to achieve consistency with any new Oregon Health Plan/OHA premium levels.

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

8.8 MLR Reporting for 2020.

CMHPs shall submit to Health Plan a report for the cost year January 1, 2020 – December 31, 2020 no later than March 30, 2021 using a format accepted by OHA. CMHPs shall refer to "2020 Medical Loss Ratio Rebate Instructions" (as published on the OHA CCO Contract Forms website at http://www.oregon.gov/oha/healthplan/Pages/cco-contract-forms.aspx) for support.

8.9 MLR Reporting for 2021.

CMHPs shall submit to Health Plan reports for the cost year January 1, 2021 – December 31, 2021 no later than March 30, 2022 using a format accepted by OHA. CMHPs shall refer to "2021 Medical Loss Ratio Rebate Instructions" (as published on the OHA CCO Contract Forms website at http://www.oregon.gov/oha/healthplan/Pages/cco-contract-forms.aspx) for support.

8.10 Health Related Services (Flexible Services and Community Based Health-Related Services.

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

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

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

8.12 Corrective Action Plans

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

8.13 Cooperation and Engagement in Quality Improvement Process.

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

8.14 Member Assignment

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

Overage Settlement Example

ST CHARLES OHP HOSPITAL CAPITATION REPORT

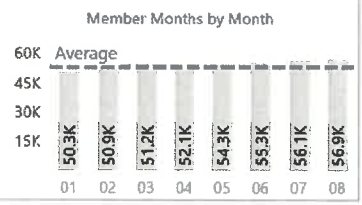
CENTRAL OREGON CCO
Coordinated Care Organization (Medicaid)

Incurred: 01/2020 - 08/2020
Paid through: 10/2020

FINANCIALS

MEMBERS

Member Months: 427,051
Average Membership: 53,381



HOSPITAL CAPITATION		PMPM
Hospital Capitation (Total)	$46.8M	$109.7
Hospital Cap Withhold (HCW)	$5.8M	$13.5
Hospital Capitation (w/o Withhold)	$41.1M	$96.1
HCW Eligible for Return (SCHS Estimate at 49%)	$3.0M	$7.1
Hospital Cap + Estimated SCHS HCW Eligible Return	$44.1M	$103.2

	IP	NON-IP	TOTAL
Billed Charges	$137.05M	$111.16M	$248.21M
Billed Completed	$140.40M	$113.88M	$254.27M
Billed PMPM (COMPL)	$328.76	$266.66	$595.41
FFS est	$21.16M	$20.48M	$41.64M
FFS Est Completed	$21.68M	$20.98M	$42.66M
FFS PMPM (COMPL)	$50.77	$49.13	$99.90
FFS Equiv/Billed (%)	15.4%	18.4%	16.8%

WITHHOLD RETURNED DUE TO COVID19
Incurred 202004 - 202010, Paid Through 202010

HCW Return IPA + SCMG	$2,339,498	$5.99
HCW Return SCHS	$2,339,498	$5.99
HCW Return CMHP	$95,490	$0.24

FFS Equivalent (Completed) vs. Hosp Cap with Return: 93.2%

FFS Equivalent (Completed) vs. Hosp Cap: 87.7%

Exhibit H
CCO Fee-for-service and Capitation for Behavioral Health Services
Community Mental Health Program for Central Oregon CCO
Effective 04/01/2021

CMHP Fee-for service and Monthly Capitation Payment

Health Plan will reimburse CMHPs for Therapy Services and Assessment Services on a Fee-for-service basis and on a capitation PMPM basis for Non Encounterable Health Care Costs and Program Allocation costs according to the below rate schedule:

Intensive In-Home Behavioral Health Treatment (IIBHT) Deschutes County Health Services:
CMHP shall provide access to Intensive In-Home Behavioral Health Treatment (IIBHT) services for all eligible Members age twenty (20) and younger in accordance with OARs 309-019- 0167, 410-172-0650, and 410-172-0695. For Deschutes County, IIBHT services shall be submitted using HCPCS code of H0023 and shall be reimbursed through the below capitation table. The services under H0023 are separate from services billed for Behavioral Health outreach and engagement, for which a CPT code will be designated by Health Plan. Until such a time as an alternative code is identified, CMHP will submit non-billable Behavioral Health Outreach and Engagement (H0023) claims valued at the agreed rate of $169.90 and attributed to Non-Encounterable Healthcare Services Costs in the capitation portion of this contract.

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

Therapy Services FFS CPT Codes: 90832, 90834, 90837, 90846, 90847, H0004, H0005, H0016, H0038 at 130% of the current OHA fee schedule (with an 8% Claims Risk Withhold)

Assessment Services FFS CPT Codes: 90791, 90792, H0001, H0031, H2000 at 165% of current OHP fess schedule (with an 8% Claims Risk Withhold)

	Non Encounterable services and all other CMHP billed services PMPM	Program Allocation PMPM
Deschutes County Health Services, Public Health Division members domiciled in Deschutes/Klamath County	$14.09	$5.00
BestCare members domiciled in Jefferson County	$12.15	$7.84
BestCare domiciled in Crook County	$12.15	$7.84

CMHP Performance Measure Withhold

Eight percent (8%) will be withheld from the CMHP Fee-for-services payments. These amounts will be reconciled consistent with Exhibit G.

Non Encounterable services/other billed services and Program Allocation Definition:
CMHPs shall provide and report non-encounterable services and system supports. Non-encounterable services and system supports include, but are not limited to: travel, prevention, education and outreach, internal case consultation, co-provided services, outreach and engagement, socialization, and psycho-educational services that are not otherwise encounterable.

Exhibit I
System of Care Governance
Effective 04/01/2021

SECTION 1. PRACTICE LEVEL WORKGROUP. County shall establish, support, and manage a Practice Level Workgroup that performs the following work:

1.1 Reviews Wraparound practice barriers;
1.2 Removes barriers when possible; and
1.3 Submit unresolved system barriers to the Advisory Committee and/or Executive Committee for resolution and/or advancement to the State System of Care Steering Committee.

The Practice Level Workgroup shall consist of representatives of organizations who supervise individuals from local public child serving agencies (Child Welfare, education, juvenile justice, Oregon Youth Authority, Tribal communities, intellectual/development disabilities, Behavioral Health) and shall include meaningful participation from youth and family members. County shall develop a formal charter and new member handbook for the Practice Level Workgroup. County shall report quarterly to Contractor on the progress and work of the Practice Level Workgroup.

SECTION 2. ADVISORY COMMITTEE. County shall establish, support, and manage an Advisory Committee that performs the following work:

1.1 Advises on policy development and implementation;
1.2 Reviews Fidelity and outcomes;
1.3 Provides oversight using a strategic plan; and
1.4 Responds to system barriers that the Practice Level Workgroup cannot resolve, including making recommendations to the Executive Council when necessary.

The Advisory Committee shall consist of representatives of Contractor, Contractor's Participating Providers, local public child serving agencies (Child Welfare, education, juvenile justice, Oregon Youth Authority, Tribal communities, intellectual/development disabilities, Behavioral Health), all of whom must have authority to make program level financial and policy changes, and the Advisory Committee must include meaningful participation of youth and family members.

SECTION 3. EXECUTIVE COMMITTEE. County shall create, support, and manage an Executive Committee that performs the following work:

1.1 Develops and approves policies and shared decision-making regarding funding and resource development;

1.2 Reviews project outcomes; and

1.3 Identifies unmet needs in the community to support the expansion of the service array.

The Executive Committee shall consist of representatives of Contractor, Contractor's Participating Providers, local public child serving agencies (Child Welfare, education, juvenile

justice, Oregon Youth Authority, Tribal communities, intellectual/development disabilities, Behavioral Health), all of whom must have authority to make program level financial and policy changes, and the Executive Committee must include meaningful participation of youth and family members.

SECTION 4. POLICIES, PROCEDURES, AND REPORTING DELIVERABLES. County shall create, maintain, and update policies, procedures, and reporting deliverables to permit Contractor to comply with the CCO Contract. County agrees to submit materials to Contractor for Contractor's review, as described below:

SOC quarterly reporting due to PSCS no later than March 15, June 15, September 15 and December 15, 2020 to include all of the following information:

a) Barriers that were submitted by the community to the appropriate committee within the SOC governance structure:
b) Resolved and unresolved outcomes and barriers that were sent to the Statewide SOC steering Committee:
c) Sources of Funding within the SOC governance structure and what type of funding was used:
d) List of system partners involved: and
e) Data informed priorities for the following contract year.

Report	Deliverables	Due Date
SOC Quarterly Report	a) Barriers that were submitted by the community to the appropriate committee within the SOC governance structure: b) Resolved and unresolved outcomes and barriers that were sent to the Statewide SOC steering Committee: c) Sources of Funding within the SOC governance structure and what type of funding was used: d) List of system partners involved: and e) Data informed priorities for the following contract year.	Annually on 3/15, 6/15, 9/15, 12/15
Charters	a.) Submit a charter for the Practice Level Workgroup b.) Submit a charter for the Advisory Council c.) Submit a charter for the Executive Council	Annually by March 15th
New Member Handbook	a.) Submit a New Member Handbook and distribute same to each new member of the SOC Governance structure	Annually by March 15th
Minutes	a.) Maintain a formal written record of all System of Care governance activities and make records available at the request of PacificSource Community Solutions or the Oregon Health Authority.	As requested.

EXHIBIT I-1

FIDELITY WRAPAROUND SERVICES

Effective 04/01/2021

RECITALS

A. PacificSource is committed to implementing Oregon Health Policy Board Policy #26 ("System of Care (SOC) to be fully implemented for the children's system") and Policy #27 ("Require wraparound is available to all children and young adults who meet criteria"), reducing billing system and policy barriers that may prevent community-based providers from billing for services, and developing payment methodologies to reimburse for evidence-based treatments in a community setting.

B. Wraparound is an intensive care coordination process for youth with emotional and behavioral disorders who are involved in multiple systems. These systems include 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 a positive set of outcomes.

C. PacificSource is also 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.

D. 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 309-019-0326. Provider delivers wraparound supports pursuant to Fidelity Wraparound requirements, as required by OAR 309-019-0326 and Exhibit M of the CCO Contract.

E. PacificSource is including this Attachment by Amendment for the express purpose of supporting wraparound services.

1. WRAPAROUND WORK

PacificSource 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 PacificSource 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 Exhibit M of the CCO Contract. In particular, Provider shall:

1.3.1 Ensure certified providers administer the Child and Adolescent Needs and Strengths Assessment ("CANS") Oregon to members, consistent with the reporting requirements set forth in Exhibit M of the CCO Contract;

1.3.2 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;

1.3.3 Adhere to applicable elements of the System of Care Wraparound Initiative Guidance Document published by the OHA; and

1.3.4 Complete required documents for each enrolled youth and their family pursuant to the Fidelity model.

1.4 **PacificSource's Wraparound Policies.** Provider agrees to comply with PacificSource'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 PacificSource in improving its policies and procedures to meet the needs of the local community.

1.5 **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.

1.6 **Workforce.** On not less than an annual basis, Provider agrees to share with PacificSource 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. This information will assist PacificSource in meeting the OHA's mandate to align local interests with state-level expectations and increase the number of certified Traditional Health Workers serving the community. After Provider produces this analysis, the Parties agree to meet and review the analysis to discuss barriers and opportunities.

1.7 **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.

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

1.9 **Wraparound Care Coordinators.** Provider agrees to work collaboratively with PacificSource's wraparound care coordinators and supervisors ("Wraparound Staff") and other community care coordinators, as reasonably requested. Provider also agrees to participate in technical assistance offered by PacificSource, including training in trauma-informed care principles.

1.10 **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.

1.11 **Participation in Community Governance.** Provider agrees to participate in the local Community Health Assessment and Community Health Improvement Plan, as may be requested by PacificSource or the Central Oregon Health Council (COHC), from time to time. In addition, Provider agrees to participate in the Community Advisory Council to share valuable perspectives with the community and the COHC.

1.12 **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 PacificSource so that PacificSource may take appropriate next steps pursuant to PacificSource's policies and procedures.

1.13 **Data Collection and Reporting.** In order to support Provider and PacificSource'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 PacificSource that includes the following:

- Baseline utilization and number of clients served (based on 2019 services rendered)
- Counts of Members and families served (monthly)
- Ratio of employed or contracted staff to total number of Members and families served (monthly)
- Number of requests from Members and families for services (monthly)
- CANS Data Request (Quarterly)
- WFI-EZ completed forms (following six months of Member enrollment in Wraparound services).

1.14 **Reporting Penalties.** Provider agrees to supply the reporting deliverables listed in SECTION 11. Provider agrees to indemnify and hold PacificSource 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.

1.15 **Workforce Training.** Provider, in partnership with PacificSource, shall identify training needs of its staff and shall address such needs to improve the ability of Provider to deliver Services to assigned Members. Provider shall ensure that all staff receive training as required in the Contract such as, but not limited to, Cultural Responsiveness, Implicit Bias, CLAS Standards, Trauma Informed Care, and uses of data to advance health equity to name a few. Provider shall have mechanisms in place that enable reporting to PacificSource, at PacificSource'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 PacificSource with an Annual Training and Education Report so that PacificSource may compile such information into PacificSource's report to the OHA.

2. PAYMENT

Provider shall be paid for providing the Wraparound Work pursuant to Attachment H 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 309-019-0326, and agree to work together to ensure the proper completion and filing of such reports so that PacificSource 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 PacificSource will have the right to make the final redactions based on its sole discretion.

Crook County Counsel's Office

Mailing: 300 NE Third St., Prineville, OR 97754 • Phone: 541-416-3919
Physical: 267 NE 2nd St., Ste 200, Prineville, OR 97754 • Fax: 541-447-6705

MEMO

TO: Crook County Court

FROM: Eric Blaine, County Counsel

DATE: April 26, 2021

RE: *IGA 166039 for the Financing of Community Mental Health, Addiction Treatment, Recovery and Prevention, and Problem Gambling Services*

Amendment 1 to IGA 166039

Our File No.: MH 40

At the April 7 meeting, the County Court discussed the ongoing concerns regarding the proposed 212-page Community Mental Health Program (CMHP) funding agreement. In short, the concern of many Oregon counties is that an unacceptable degree of risk is being transferred from the State to the counties through this year's iteration of the agreement. Many counties have withheld signatures while attempting to negotiate a possible solution.

The Oregon Health Authority has declined to extend any contractual immunity, or greater indemnification or contribution language in the agreements. They have, however, proposed to work with counties to obtain additional insurance coverages. The County's mental health services director, Rick Treleaven, has recommended that Crook County sign the agreement while those discussions are ongoing. Jefferson County, Washington County, and Clackamas County have all scheduled their version of this agreement for future commissioner meetings.

Also attached to this document is the first amendment to the agreement. This adds a new service element and provides funding to operate that service for the next two years.

Please place this memo and the attached document(s) on the Wednesday, May 5, 2021 County Court Agenda to the current Discussion item.

In compliance with the Americans with Disabilities Act, this document is available in alternate formats such as Braille, large print, audio recordings, Web-based communications and other electronic formats. To request an alternate format, please send an e-mail to dhs-oha.publicationrequest@state.or.us or call 503-378-3486 (voice) or 503-378-3523 (TTY) to arrange for the alternative format.

AGREEMENT #166039

2021 INTERGOVERNMENTAL AGREEMENT FOR THE FINANCING OF COMMUNITY MENTAL HEALTH, ADDICTION TREATMENT, RECOVERY, & PREVENTION, AND PROBLEM GAMBLING SERVICES

This 2021 Intergovernmental Agreement for the Financing of Community Mental Health, Addiction Treatment, Recovery, & Prevention, and Problem Gambling Services (the "Agreement") is between the State of Oregon acting by and through its Oregon Health Authority ("OHA") and **Crook County**, a political subdivision of the State of Oregon ("County").

RECITALS

WHEREAS, **ORS 430.610(4) and 430.640(1)** authorize OHA to assist Oregon counties and groups of Oregon counties in the establishment and financing of Community Mental Health, Addiction Treatment, Recovery, & Prevention Services, and Problem Gambling programs operated or contracted for by one or more counties;

WHEREAS, County has established and proposes, during the term of this Agreement, to operate or contract for the operation of Community Mental Health, Addiction Treatment, Recovery, & Prevention Services, and Problem Gambling programs in accordance with the policies, procedures and administrative rules of OHA;

WHEREAS, County has requested financial assistance from OHA to operate or contract for the operation of its Community Mental Health, Addiction Treatment, Recovery, & Prevention Services, and Problem Gambling programs;

WHEREAS, in connection with County's request for financial assistance and in connection with similar requests from other counties, OHA and representatives of various counties requesting financial assistance, including the Association of Oregon Counties, have attempted to conduct agreement negotiations in accordance with the Principles and Assumptions set forth in a Memorandum of Understanding that was signed by both parties;

WHEREAS, OHA is willing, upon the terms of and conditions of this Agreement, to provide financial assistance to County to operate or contract for the operation of its Community Mental Health, Addiction Treatment, Recovery, & Prevention Services, and Problem Gambling programs;

WHEREAS, various statutes authorize OHA and County to collaborate and cooperate in providing for basic Community Mental Health, Addiction Treatment, Recovery, & Prevention Services, and Problem Gambling programs and incentives for community-based care in a manner that ensures appropriate and adequate statewide service delivery capacity, subject to availability of funds; and

WHEREAS, within existing resources awarded under this Agreement and pursuant to ORS 430.630(9)(b) through 430.630(9)(h),each Local Mental Health Authority that provides Community Mental Health, Addiction Treatment, Recovery, & Prevention, or Problem Gambling Services, or any combination thereof, shall determine the need for local Community Mental Health, Addiction Treatment,

Recovery, & Prevention Services, or Problem Gambling Services, or any combination thereof, and adopt a comprehensive Local Plan for the delivery of Community Mental Health, Addiction Treatment, Recovery, & Prevention Services, or Problem Gambling Services, or any combination thereof, for children, families, adults and older adults that describes the methods by which the Local Mental Health Authority shall provide those services. The Plan shall be consistent with content and format to that of OHA's Local Plan guidelines located at http://www.oregon.gov/oha/amh/Pages/contracts.aspx. County shall provide services per the Local Plan as agreed upon between OHA and County.

NOW, THEREFORE, in consideration of the foregoing premises and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereto agree as follows:

AGREEMENT

1. **Effective Date and Duration.** This Agreement shall become effective on January 1, 2021. Unless terminated earlier in accordance with its terms, this Agreement shall expire on December 31, 2021.

2. **Agreement Documents, Order of Precedence.** This Agreement consists of the following documents:

   This Agreement without Exhibits

Exhibit A	Definitions
Exhibit B-1	Service Descriptions
Exhibit B-2	Specialized Service Requirements
Exhibit C	Financial Assistance Award
Exhibit D	Payment, Settlement, and Confirmation Requirements
Exhibit E	Special Terms and Conditions
Exhibit F	General Terms and Conditions
Exhibit G	Standard Terms and Conditions
Exhibit H	Required Federal Terms and Conditions
Exhibit I	Required Provider Contract Provisions
Exhibit J	Provider Insurance Requirements
Exhibit K	Startup Procedures
Exhibit L	Catalog of Federal Domestic Assistance (CFDA) Number Listing

   In the event of a conflict between two or more of the documents comprising this Agreement, the language in the document with the highest precedence shall control. The precedence of each of the documents comprising this Agreement is as follows, listed from highest precedence to lowest precedence: (a) this Agreement without Exhibits, (b) Exhibit H, (c) Exhibit A, (d) Exhibit C, (e) Exhibit D, (f) Exhibit E, (g) Exhibit B-1, (h) Exhibit B-2, (hi) Exhibit G, (j) Exhibit F (k) Exhibit I, (l) Exhibit J, (m) Exhibit K, (n) Exhibit L.

EACH PARTY, BY EXECUTION OF THIS AGREEMENT, HEREBY ACKNOWLEDGES THAT IT HAS READ THIS AGREEMENT, UNDERSTANDS IT, AND AGREES TO BE BOUND BY ITS TERMS AND CONDITIONS.

3. Signatures.

Crook County
By:

Authorized Signature	Printed Name	Title	Date

State of Oregon, acting by and through its Oregon Health Authority
By:

Authorized Signature	Printed Name	Title	Date

Approved by: Director, OHA Health Systems Division
By:

Authorized Signature	Printed Name	Title	Date

Approved for Legal Sufficiency:

Approved by Steven Marlowe, Senior Assistant Attorney General, Department of Justice, Tax & Finance Section, on January 29, 2021; email in Contract file.

OHA Program:
Approved by Sheryl Derting on February 4, 2021; email in Contract file.

2021 INTERGOVERNMENTAL AGREEMENT
FOR THE FINANCING OF COMMUNITY MENTAL HEALTH, ADDICTION TREATMENT, RECOVERY, & PREVENTION, AND PROBLEM GAMBLING SERVICES

EXHIBIT A
DEFINITIONS

As used in this Agreement, the following words and phrases shall have the indicated meanings. Certain additional words and phrases are defined in the Service Descriptions, Specialized Service Requirements and Special Conditions in the Financial Assistance Award. When a word or phrase is defined in a particular Service Description, Specialized Service Requirement or Special Condition in the Financial Assistance Award, the word or phrase shall not have the ascribed meaning in any part of the Agreement other than the particular Service Description, Specialized Service Requirement or Special Condition in which it is defined.

1. **"Addiction Treatment, Recovery, & Prevention Services"** means treatment Services for Individuals diagnosed with disorders related to the taking of a drug of abuse including alcohol, to the side effects of a medication, and to a toxin exposure. The disorders include substance use disorders such as substance dependence and substance abuse, and substance-induced disorders, including substance intoxication, withdrawal, delirium, and dementia, as well as substance induced psychotic disorder, mood disorder, etc., as defined in DSM criteria.

2. **"Aging and People with Disabilities" or "APD"** means a division within the Department of Human Services that is responsible for management, financing and regulation services for aging adults and people with disabilities.

3. **"Agreement Settlement"** means OHA's reconciliation, after termination or expiration of this Agreement, of amounts OHA actually disbursed to County with amounts that OHA is obligated to pay to County under this Agreement from the Financial Assistance Award, as determined in accordance with the financial assistance calculation methodologies set forth in the Service Descriptions. OHA reconciles disbursements and payments on an individual Service basis as set forth in the Service Descriptions and in accordance with Exhibit F, Section 1., "Disbursement and Recovery of Financial Assistance."

4. **"Allowable Costs"** means the costs described in 2 CFR Part 200 or 45 CFR Part 75, as applicable, except to the extent such costs are limited or excluded by other provisions of this Agreement, whether in the applicable Service Descriptions, Specialized Service Requirements, Special Conditions identified in the Financial Assistance Award, or otherwise.

5. **"Behavioral Health"** refers to mental/emotional wellbeing and/or actions that affect wellness. Behavioral health problems include substance abuse and misuse, Problem Gambling, and Mental Health disorders as well as serious psychological distress and suicide.

6. **"Client"** or "Individual" means, with respect to a particular Service, any person who is receiving that Service, in whole or in part, with funds provided under this Agreement.

7. **"Community Mental Health Program" or "CMHP"** means an entity that is responsible for planning the delivery of Services for Individuals with mental or emotional disturbances, drug abuse, alcohol abuse or gambling addiction problems in a specific geographic area of the state under an agreement with OHA or a Local Mental Health Authority.

8 **Community Mental Health** means programs and Services, delivered in the community, for Individuals diagnosed with Serious and Persistent Mental Illness (SPMI) or other mental or emotional disturbances..

9. **"Coordinated Care Organizations" or "CCO"** means a corporation, governmental agency, public corporation, or other legal entity that is certified as meeting the criteria adopted by the Oregon Health Authority under ORS 414.625 to be accountable for care management and to provide integrated and coordinated health care for each of the organization's members.

10. **"County Financial Assistance Administrator"** means a County appointed officer to administer this Agreement and amend the Financial Assistance Award on behalf of County, by execution and delivery of amendments to this Agreement in the name of County, in hard copy or electronically.

11. **"DHS"** means the Department of Human Services of the State of Oregon.

12. **"Federal Funds"** means all funds paid to County under this Agreement that OHA receives from an agency, instrumentality or program of the federal government of the United States.

13. **"Financial Assistance Award" or "FAA"** means the description of financial assistance set forth in Exhibit C, "Financial Assistance Award," attached hereto and incorporated herein by this reference; as such Financial Assistance Award may be amended from time to time. Disbursement of funds identified in the FAA is made by OHA using procedures described in Exhibit B-1, "Service Descriptions," and Exhibit B-2, "Specialized Service Requirements," for each respective Service.

14. **"Gambling Disorder"** means persistent and recurrent problematic gambling behavior leading to clinically significant impairment or distress.

15. **"Health Services Division" or "HSD"** means for the purpose of this Agreement, the division of OHA that is responsible for Community Mental Health, Addiction Treatment, Recovery, & Prevention, and Problem Gambling Services.

16. **"Individual"** or "client" means, with respect to a particular Service, any person who is receiving that Service, in whole or in part, with funds provided under this Agreement.

17. **"Interim Services"** as described in 45 CFR §96.121, means:

    a. Services provided, until an Individual is admitted to substance abuse treatment program, for reducing the adverse health effects of such abuse, promoting the health of the Individual, and reducing the risk of transmission of disease. At a minimum Services include counseling and education about HIV and tuberculosis, the risks of needle sharing, the risks of transmission of disease to sexual partners and infants, and steps that can be taken to ensure that HIV and tuberculosis transmission does not occur;

    b. Referral for HIV or TB treatment Services, where necessary; and

    c. Referral for prenatal care, if appropriate, until the Individual is admitted to a Provider's Services.

    d. If County treats recent intravenous drug users (those who have injected drugs within the past year) in more than one-third of its capacity, County shall carry out outreach activities to encourage individual intravenous drug users in need of such treatment to undergo treatment and shall document such activities.

18. **"Local Mental Health Authority" or "LMHA"** means one of the following entities:

    a. The board of county commissioners of one or more counties that establishes or operates a Community Mental Health Program;

b. The tribal council, in the case of a federally recognized tribe of Native Americans, that elects to enter into an agreement to provide mental health services; or

c. A regional local mental health authority comprised of two or more boards of county commissioners.

19. **"Local Plan"** or **"Plan"** means a plan adopted by the Local Mental Health Authority directed by and responsive to the Behavioral Health needs of the community consistent with the requirements identified in ORS 430.630.

20. **"Medicaid"** means federal funds received by OHA under Title XIX of the Social Security Act and Children's Health Insurance Program (CHIP) funds administered jointly with Title XIX funds as part of state medical assistance programs by OHA.

21. **"Misexpenditure"** means funds, other than an Overexpenditure, disbursed to County by OHA under this Agreement and expended by County that is:

a. Identified by the federal government as expended contrary to applicable statutes, rules, OMB Circulars or 45 CFR Part 75, as applicable, or any other authority that governs the permissible expenditure of such funds, for which the federal government has requested reimbursement by the State of Oregon, whether in the form of a federal determination of improper use of federal funds, a federal notice of disallowance, or otherwise; or

b. Identified by the State of Oregon or OHA as expended in a manner other than that permitted by this Agreement, including without limitation any funds expended by County contrary to applicable statutes, rules, OMB Circulars or 45 CFR Part 75, as applicable, or any other authority that governs the permissible expenditure of such funds; or

c. Identified by the State of Oregon or OHA as expended on the delivery of a Service that did not meet the standards and requirements of this Agreement with respect to that Service.

22. **"Measures and Outcomes Tracking System" or "MOTS"** means the OHA data system that stores data submitted by OHA contractors and subcontractors.

23. **"Oregon Health Authority" or "OHA"** means the agency within the State of Oregon that is responsible for Problem Gambling, Addiction Treatment, Recovery, & Prevention Services, children and adult Community Mental Health Services, and maintaining custody of persons committed to the state, by courts, for care and treatment of mental illness.

24. **"Overexpenditure"** means funds disbursed to County by OHA under this Agreement and expended by County that is identified by the State of Oregon or OHA, through Agreement Settlement or any other disbursement reconciliation permitted or required under this Agreement, as in excess of the funds County is entitled to as determined in accordance with the financial assistance calculation methodologies set forth in the applicable Service Descriptions or in Exhibit E, "Special Terms and Conditions."

25. **"Problem Gambling Services"** means prevention, treatment, maintenance and recovery Services for Individuals diagnosed with Gambling Disorder or are at risk of developing Gambling Disorder including or inclusive of any family and or significant other impacted by the problem gambler for access to treatment. For the purposes of this Agreement, Problem Gambling Services and Gambling Disorder will be used interchangeably.

26. **"Program Area"** means any one of the following: Community Mental Health Services, Addiction Treatment, Recovery, & Prevention Services, or Problem Gambling Services.

27. **"Provider"** has the meaning set forth in section 5 of Exhibit F, "General Terms and Conditions." As used in a Service Description and elsewhere in this Agreement where the context requires, Provider also includes County if County provides the Service directly.

28. **"Provider Contract"** has the meaning set forth in Exhibit F, "General Terms and Conditions," section 5.29. **"Serious and Persistent Mental Illness (SPMI)** means the current DSM diagnostic criteria for at least one of the following conditions as a primary diagnosis for an adult age 18 or older:

a. Schizophrenia and other psychotic disorders;
b. Major depressive disorder;
c. Bipolar disorder;
d. Anxiety disorders limited to Obsessive Compulsive Disorder (OCD) and Post Traumatic Stress Disorder (PTSD);
e. Schizotypal personality disorder; or
f. Borderline personality disorder.

30. **"Service(s)"** or "Service Element(s)" means any one of the following services or group of related services as described in Exhibit B-1, "Service Descriptions," in which costs are covered in whole or in part with financial assistance pursuant to Exhibit C, "Financial Assistance Award," of this Agreement. Only Services in which costs are covered in whole or in part with financial assistance pursuant to Exhibit C, "Financial Assistance Award," as amended from time to time, are subject to this Agreement.

Service Name	Service Code
System Management and Coordination – Addiction Treatment, Recovery, & Prevention Services	A&D 03
Start-Up – Addiction Treatment, Recovery, & Prevention Services	A&D 60
Adult Addiction Treatment, Recovery, & Prevention Residential Treatment Services	A&D 61
Supported Capacity for Dependent Children Whose Parents are in Adult Addiction Treatment, Recovery, & Prevention Residential Treatment	A&D 62
Peer Delivered Services – Addiction Treatment, Recovery, & Prevention Services	A&D 63
Housing Assistance – Addiction Treatment, Recovery, & Prevention Services	A&D 64
Intoxicated Driver Program Fund (IDPF)	A&D 65
Community Behavioral and Addiction Treatment, Recovery, & Prevention Services	A&D 66
Addiction Treatment, Recovery, & Prevention Residential and Day Treatment Capacity	A&D 67
Youth Addiction, Recovery, & Prevention Residential Treatment Services	A&D 71
Problem Gambling Prevention Services	A&D 80
Problem Gambling Treatment Services	A&D 81
Problem Gambling Residential Services	A&D 82
Problem Gambling Respite Treatment Services	A&D 83

Service Name	Service Code
Problem Gambling, Client Finding Outreach Services	A&D 84
System Management and Coordination – Community Mental Health	MHS 01
Aid and Assist Client Services	MHS 04
Assertive Community Treatment Services	MHS 05
Crisis and Acute Transition Services (CATS)	MHS 08
Jail Diversion	MHS 09
Mental Health Promotion and Prevention Services	MHS 10
Rental Assistance Program Services	MHS 12
School-Based Mental Health Services	MHS 13
Young Adult Hub Programs (YAHP)	MHS 15
Non-Residential Community Mental Health Services For Adults, Children and Youth	MHS 20
Acute and Intermediate Psychiatric Inpatient Services	MHS 24
Community Mental Health Crisis Services For Adults and Children	MHS 25
Non-Residential Community Mental Health Services For Youth and Young Adults In Transition	MHS 26
Residential Community Mental Health Treatment Services for Youth and Young Adults In Transition	MHS 27
Residential Community Mental Health Treatment Services For Adults	MHS 28
Monitoring, Security, and Supervision Services for Individuals Under the Jurisdiction of the Adult and Juvenile Panels of the Psychiatric Security Review Board	MHS 30
Enhanced Care And Enhanced Care Outreach Services	MHS 31
Adult Foster Care Services	MHS 34
Older or Disabled Adult Community Mental Health Services	MHS 35
Pre-Admission Screening and Resident Review Services (PASARR)	MHS 36
Start-Up – Community Mental Health Services	MHS 37
Supported Employment Services	MHS 38
Projects For Assistance In Transition From Homelessness (PATH) Services	MHS 39

31. **"Service Description"** means the description of a Service or Service Element as set forth in Exhibit B-1, "Service Descriptions."

32. **"Specialized Service Requirement"** means any one of the following specialized service requirements as described in Exhibit B-2, "Specialized Service Requirements," in which costs are covered in whole or in part with financial assistance pursuant to Exhibit C, "Financial Assistance Award," of this Agreement. Only Services in which costs are covered in whole or in part with financial assistance pursuant to Exhibit C, "Financial Assistance Award," as amended from time to time, are subject to this Agreement.

Specialized Service Requirement Name	Specialized Service Requirement Code
Veterans Peer Delivered Services	MHS 16A
Early Assessment and Support Alliance (EASA)	MHS 26A
Secure Residential Treatment Facility	MHS 28A
Gero-Specialist	MHS 35A
APD Residential	MHS 35B

33. **"Trauma Informed Services"** means Services that are reflective of the consideration and evaluation of the role that trauma plays in the lives of people seeking Community Mental Health and Addiction Treatment, Recovery, & Prevention Services, including recognition of the traumatic effect of misdiagnosis and coercive treatment. Services are responsive to the vulnerabilities of trauma survivors and are delivered in a way that avoids inadvertent re-traumatization and facilitates individual direction of services.

34. **"Underexpenditure"** means funds disbursed by OHA under this Agreement that remain unexpended at Agreement termination or expiration, other than funds County is permitted to retain and expend in the future under Exhibit F, "General Terms and Conditions," section 3.b.

2021 INTERGOVERNMENTAL AGREEMENT
FOR THE FINANCING OF COMMUNITY MENTAL HEALTH, ADDICTION TREATMENT, RECOVERY, & PREVENTION, AND PROBLEM GAMBLING SERVICES

EXHIBIT B-1
SERVICE DESCRIPTIONS

Not all Services described in this Exhibit B-1 may be covered in whole or in part with financial assistance pursuant to Exhibit C, "Financial Assistance Award," of this Agreement. Only Services in which costs are covered in whole or in part with financial assistance pursuant to Exhibit C, "Financial Assistance Award," as amended from time to time, are subject to this Agreement.

1. Service Name: **SYSTEM MANAGEMENT AND COORDINATION – ADDICTION TREATMENT, RECOVERY & PREVENTION AND PROBLEM GAMBLING SERVICES**

Service ID Code: **A&D 03**

a. Service Description

System Management and Coordination – Addiction Treatment, Recovery, & Prevention and Problem Gambling Services (A&D 03 Services) is the central management of an Addiction Treatment, Recovery, & Prevention and Problem Gambling Services system on behalf of an LMHA for which financial assistance is included in Exhibit C, "Financial Assistance Award," of this Agreement. A&D 03 Services include planning and resource development, coordination of Service delivery for Addiction Treatment, Recovery, & Prevention and Problem Gambling Services, negotiation and monitoring of contracts and subcontracts, and documentation of Service delivery in compliance with state and federal requirements.

b. Performance Requirements

In providing A&D 03 Services, County must comply with OAR 309-014-0000 through 309-014-0040, as such rules may be revised from time to time.

No special reporting requirements.

c. Financial Assistance Calculation, Disbursement, and Confirmation of Performance and Reporting Requirements Procedures

See Exhibit D, Payment, Settlement, and Confirmation Requirements.

Use Payment and Confirmation language.

2. **Service Name:** **START-UP**

Service ID Code: **A&D 60**

a. **Service Description**

Funds awarded must be used for Start-Up activities as described in a special condition in Exhibit C, "Financial Assistance Award." Description of Start-Up activities are activities necessary to begin, expand, or improve Substance Use Disorder and Problem Gambling Services. These expenses are distinct from routine operating expenses incurred in the course of providing ongoing services. Notwithstanding the description of the Start-Up activities in a special condition, funds awarded from A&D 60 may not be used for real property improvements of $10,000 and above. When OHA funds in the amount of $10,000 and above are to be used for purchase or renovation of real property, County shall contact the Housing Development Unit of OHA and follow procedures as prescribed by that unit.

A&D 60 funds are typically disbursed prior to initiation of Services and are used to cover approved allowable Start-up expenditures, as described in Exhibit K, "Start-Up Procedures," that will be needed to provide the Services planned and to be delivered at the specified site(s).

b. **Performance Requirements**

The funds awarded for A&D 60 may be expended only in accordance with Exhibit K, "Start-Up Procedures," which is incorporated herein by this reference.

c. **Special Reporting Requirements**

Using the OHA prescribed "Start-Up Request & Expenditure Form," County shall prepare and submit electronically, to amhcontract.administrator@dhsoha.state.or.us, a request for disbursement of allowable Start-Up funds as identified in a special condition in a particular line of Exhibit C, "Financial Assistance Award." The reports must be prepared in accordance with forms prescribed by OHA and procedures described in Exhibit K, "Start-Up Procedures." Forms are located at http://www.oregon.gov/OHA/HSD/AMH/Pages/Reporting-Requirements.aspx.

d. **Financial Assistance Calculation, Disbursement, and Agreement Settlement Procedures**

See Exhibit D, Payment, Settlement, and Confirmation Requirements.

Use Payment Start-Up, and Settlement Start-Up language.

3. **Service Name:** **ADULT SUBSTANCE USE DISORDER RESIDENTIAL TREATMENT SERVICES**

Service ID Code: **A&D 61**

a. **Service Description**

Adult Substance Use Disorder Residential Treatment Services (A&D 61) are Services delivered to Individuals 18 years of age or older who are unable to live independently in the community; cannot maintain even a short period of abstinence from substance abuse; are in need of 24-hour supervision, treatment, and care; and meet the treatment placement criteria indicated in the American Society of Addiction Medicine (ASAM) Level 3.1 – 3.7.

The purpose of A&D 61 Services is to support, stabilize, and rehabilitate Individuals and to permit them to return to independent community living. A&D 61 Services provide a structured environment for an Individual on a 24-hour basis, consistent with Level 3.1 – 3.7 treatment, including entry, assessment, placement, service plan, service note, service record, transfer and continuity of care, co-occurring mental health and substance use disorders (COD), residential substance use disorders treatment and recovery services, and residential women's substance use disorders treatment and recovery programs, as set forth in OAR 309-018-0135 through 309-018-0160 and OAR 309-018-0170 through 309-018-0180, as such rules may be revised from time to time, as appropriate to the Individual's needs and include structured counseling, educational services, recreation services, self-help group participation services, and planning for self-directed recovery management to support the gains made during treatment. A&D 61 Services address the needs of diverse population groups within the community with special emphasis on ethnic minorities.

Providers shall have written admission policies and procedures in place for Individuals who appropriately use prescribed medications to treat addiction. Written policies and procedures must include referrals to alternate treatment resources for those not admitted to the program.

A&D 61 Services provided under this Agreement must be provided only to Individuals who are not eligible for Medicaid, who demonstrate a need for financial assistance based on an income below 200% of the current federal poverty level, and obtain insufficient healthcare coverage, including but not limited to, healthcare coverage that does not cover all of the services described herein or are limited to a limited number of days.

b. **Performance Requirements**

(1) Providers of A&D 61 Services funded through this Agreement must comply with OAR 309-018-0135 through 309-018-0180, as such rules may be revised from time to time. Providers of A&D 61 Services funded through this Agreement must also have a current approval or license issued by OHA in accordance with OAR 415-012-0000 through 415-012-0090.

(2) Subject to the preference for pregnant women and intravenous drug users described in Exhibit G, "Required Federal Terms and Conditions," County and Providers of A&D 61 Services funded through this Agreement shall give priority access to such Services first to Individuals referred by the

Department of Human Services and then to Individuals referred by Drug Treatment Courts from within the region, as such region is designated by OHA after consultation with County. For purposes of this Service Description, "Drug Treatment Court" means any court given the responsibility pursuant to ORS 3.450 to handle cases involving substance-abusing offenders through comprehensive supervision, drug testing, treatment services, and immediate sanctions and incentives. A&D 61 Services funded through this Agreement may be delivered to Individuals referred from any county within the State of Oregon and contiguous areas and no priority or preference shall be given to Individuals referred from any particular county, provider, or other entity.

(3) Providers of A&D 61 Services funded through this Agreement shall be a culturally competent program, able to meet the cultural and linguistic needs of the Individual, and shall also be a co-occurring competent program capable of delivering adequate and appropriate Services. Delivery of such Services must include, but is not limited to the following tasks, all of which must be documented in the Individual's clinical record:

(a) Address co-occurring disorders, including gambling, in program policies and procedures, client assessment, treatment and planning, program content, and transition or discharge planning;

(b) Address the interaction of the substance-related and mental health disorders in assessing each Individual's history of psychological trauma, readiness to change, relapse risk, and recovery environment;

(c) Arrange for, as needed, pharmacological monitoring and psychological assessment and consultation, either on site or through coordinated consultation off site;

(d) The provider's policies and procedures shall prohibit titration of any prescribed medications, including prescribed medications for the treatment of opioid dependence as a condition of receiving or continuing to receive treatment.

(e) In addition to all applicable statutory and constitutional rights, every individual receiving services has the right to receive medication specific to the individual's diagnosed clinical needs, including medications used to treat opioid dependence.

(f) Involve the family or significant others of the Individual in the treatment process;

(g) Obtain clinically appropriate family or significant other involvement and participation in all phases of assessment, treatment planning, and treatment;

(h) Use treatment methods, appropriate for Individuals with significant emotional disorders, that are based on sound clinical theory and professional standards of care; and

(i) Plan the transition from residential to community-based Services and supports that are most likely to lead to successful clinical outcomes for each Individual. This includes scheduling a face-to-face meeting between the Individual and the community-based outpatient provider within seven (7) days of discharge from the residential program.

(4) Quality of Services provided under this Agreement will be measured in accordance with the following criteria:

(a) **Engagement**: Engagement will be measured by reviewing the number of MOTS enrolled Individuals in treatment; and

(b) **Improvement in Life Circumstances**: Improvement in life circumstances will be measured by the number of Individuals participating in court programs (if applicable), enrolled in school or obtaining a GED, obtaining employment, returned to the community, and obtaining secured housing accommodations.

c. **Reporting Requirements**

See Exhibit E, 10.

d. **Financial Assistance Calculation, Disbursement, and Agreement Settlement Procedures**

See Exhibit D, Payment, Settlement, and Confirmation Requirements.

Use Payment and Confirmation language.

4. **Service Name:** **SUPPORTED CAPACITY FOR DEPENDENT CHILDREN WHOSE PARENTS ARE IN ADULT SUBSTANCE USE DISORDER RESIDENTIAL TREATMENT**

Service ID Code: **A&D 62**

a. **Service Description**

Supported Capacity for Dependent Children Whose Parents are in Adult Substance Use Disorder Residential Treatment (A&D 62) is housing services (room and board) delivered to Individuals who are dependent children age 18 and younger, of parent(s) who reside in substance use disorder residential treatment facilities, so the child(ren) may reside with their parent in the same substance use disorder residential treatment facility. The parent who is participating in residential treatment may or may not be a custodial parent during part or all of the treatment episode. The Department of Human Services, Child Welfare may have legal custody of the child(ren) but grant formal permission for the child(ren) to be placed with the parent during treatment and to reside in one of the dependent room and board placements.

b. **Performance Requirements**

Providers of A&D 62 Services funded through this Agreement must comply with OAR 309-018-0100 through 309-018-0180, as such rules may be revised from time to time. Providers of A&D 62 Services funded through this Agreement must also have a current license issued by OHA in accordance with OAR 415-012-0000 through 415-012-0090, as such rules may be revised from time to time, and participate in outcome studies conducted by OHA.

c. **Reporting Requirements**

See Exhibit E, 10.

d. **Special Reporting Requirements**

(1) Reports must be prepared using forms and procedures prescribed by OHA. Forms are located at http://www.oregon.gov/OHA/HSD/AMH/Pages/Reporting-Requirements.aspx.

(2) County shall prepare and electronically submit to amhcontract.administrator@dhsoha.state.or.us written quarterly summary reports on the delivery of A&D 62 Services, no later than 45 calendar days following the end of each subject quarter for which financial assistance is awarded through this Agreement.

(3) Each report shall provide the following information:
- (a) Number of parents and children residing in the substance use disorder residential treatment facilities, including length of stay; and
- (b) If the parent of dependent child(ren) are TANF eligible.

e. **Financial Assistance Calculation, Disbursement and Confirmation of Performance and Reporting Requirements Procedures**

See Exhibit D, Payment, Settlement, and Confirmation

Use Payment and Confirmation language.

5. **Service Name:** **PEER DELIVERED SERVICES**
Service ID Code: **A&D 63**

a. **Service Description**

For the purpose of A&D 63 Peer Delivered Services (A&D 63 Services), "Recovery Center," "Facilitating Center," "Peer Delivered Services," and "Peer Support Specialist" shall have the following meanings:

Recovery Centers are comprised of and led by people in recovery from Substance Use Disorders, which is defined in OAR 309-019-0105(112). The Recovery Centers maintain a structured daily schedule of activities where Peer Delivered Services may be delivered. Recovery Centers serve as recovery resources for the local community.

Facilitating Centers provide ongoing technical assistance and training for Recovery Centers and the community. Facilitating Centers provide resources and support for developing, expanding, and sustaining Recovery Centers. People in recovery must be involved in every aspect of program design and implementation.

Peer Delivered Services means an array of agency or community-based services and supports provided by peers, Peer Support Specialists, and Peer Wellness Specialists to Individuals or family members with similar lived experience. These services are intended to support the needs of Individuals and families, as applicable, as they progress through various stages in their recovery from Substance Use Disorders. Peer Delivered Services include, but are not limited to, the following:

Emotional support. Emotional support refers to demonstrations of empathy, caring, and concern that enhance self-esteem and confidence. Peer mentoring, peer coaching, and peer-led support groups are examples of peer-to-peer recovery services that provide emotional support.

Informational support. Informational support refers to sharing knowledge, information and skills. Peer-led life skills training, job skills training, educational assistance, and health and wellness information are examples of informational support.

Instrumental support. Instrumental support includes modeling and peer-assisted daily-life tasks that people with Substance Use Disorders may lack. Examples of instrumental support include getting to support groups, accessing childcare, completing job applications, locating alcohol and drug-free housing, and obtaining vocational, educational, and navigating health and social service programs.

Affiliational support. Affiliational support facilitates contact with other people to promote learning of social and recreational skills, create a community, and acquire a sense of belonging. Examples of affiliational support include introduction to Recovery Centers, alcohol and drug-free socialization opportunities, and exploring activities.

Family support. Family support includes educational, informational, and affiliation services for family members with relatives (as identified by the family) who are in recovery from Substance Use Disorders. These services are designed to help families develop and maintain positive relationships, improve family functioning, increase understanding of recovery processes, and build connections among family members for mutual support.

Peer Support Specialists are individuals as defined in OAR 309-019-0105(81), as such rules may be revised from time to time. Peer Support Specialists must comply with all requirements in accordance with OAR 410-180-0300 through 410-180-0380.

Population to be served, Eligible population, or Participants: Individuals with Substance Use Disorders and who are seeking recovery are the target population.

b. Performance Requirements

County shall use the financial assistance awarded for A&D 63 Services through this Agreement to provide Peer Delivered Services in a manner that benefits the Population to be served. The Peer Delivered Services must be delivered at Recovery Centers, agencies, or in communities, by Peer Support Specialists or Peer Wellness Specialists.

To the satisfaction of OHA, County shall ensure that Peer Delivered Services are:

(1) Delivered by Peer Support Specialists and Peer Wellness Specialists who continuously adhere to the Standards of Professional Conduct in OAR 410-180-0340;

(2) Delivered by Peer Support Specialists and Peer Wellness Specialists who are jointly supervised by clinical staff with documented training and experience with Peer Delivered Services and a certified Peer Support Specialist or Peer Wellness Specialist;

(3) Delivered in accordance with a plan developed with or by the Individual receiving Services;

(4) Documented and regularly reviewed by the Individual receiving Services; and

(5) Documented either in MOTS or MMIS or comparably reported.

Providers employing Peer Support Specialists and Peer Wellness Specialist must develop and implement quality assurance processes to improve the quality of Peer Delivered Services supported by funds provided through this Agreement. OHA may recommend additional actions to improve quality.

c. Reporting Requirements

See Exhibit E, 10.

d. Special Reporting Requirements

Reports must be prepared using forms and procedures prescribed by OHA. Forms are located at http://www.oregon.gov/OHA/HSD/AMH/Pages/Reporting-Requirements.aspx.

(1) Within 30 calendar days of the County providing A&D 63 Services, County shall prepare and electronically submit a written entry baseline assessment report to amhcontract.administrator@dhsoha.state.or.us.

(2) County shall prepare and electronically submit, to amhcontract.administrator@dhsoha.state.or.us, written quarterly summary reports on the delivery of A&D 63 Services, no later than 45 calendar days following the end of each subject quarter for which financial assistance is awarded through this Agreement.

(3) Each report shall provide the following information:

(a) The amount of financial assistance spent on A&D 63 Services as of the end of the reporting period;

(b) Number of Individuals served by Peer Support Specialist(s), categorized by age, gender, and ethnicity;

(c) Breakdown of Service received;

(d) Number of Individuals who acquired a safe, permanent, alcohol and drug free place to live in the community during Service participation;

(e) Number of Individuals who gained employment or engaged in productive educational or vocational activities during Service participation;

(f) Number of Individuals who remained crime-free during Service participation; and

(g) Number of Individuals served who are being retained from the previous quarter.

e. Financial Assistance Calculation, Disbursement, and Confirmation of Performance and Reporting Requirements Procedures

See Exhibit D, Payment, Settlement, and Confirmation Requirements.

Use Payment and Confirmation language.

6. **Service Name:** **HOUSING ASSISTANCE**

Service ID Code: **A&D 64**

a. **Service Description**

Housing Assistance Services assist Individuals, who are in recovery from Substance Use Disorders, in locating and paying for housing designated "alcohol and drug free," as defined in ORS 90.243 or approved by a Program Manager for the contracted Alcohol and Substance Use Disorder Program. Individuals who receive assistance may be living with other family members (e.g. where a parent is re-assuming custody of one or more children).

All Individuals receiving A&D 64 Services funded through this Agreement must reside in County, be in recovery from Substance Use Disorders, were previously homeless or at risk of homelessness, and be participating in a verifiable program of recovery. OHA will not provide financial assistance for A&D 64 Services under this and succeeding Agreement for more than 24 consecutive months for any particular Individual, unless approved in advance by OHA in writing.

b. **Performance Requirements**

Housing Assistance Services include:

(1) Rental Assistance in the form of cash payments, made on behalf of Individuals recovering from Substance Use Disorders, to cover all or a portion of the monthly rent and utilities for alcohol and drug free housing

(2) Housing Coordination Services in the form of staff support to assist Individuals recovering from Substance Use Disorders in locating and securing suitable housing, and referrals to other resources.

(3) Residential Costs to pay for move-in and barrier removal costs not to exceed 20% of total funds awarded to support securing and maintaining housing such as payment of rental deposits and fees, moving and storage costs, payment of past due utility bills and securing a credit report. These must be one-time payments only; no on-going expenses. Housing expenses not eligible are furnishings, appliances, household supplies and equipment; barrier removal expense not eligible are any payments made that do not advance the effort to secure rental housing.

Utilization requirements for A&D 64 will be identified in a special condition, subject to funds awarded in a particular line of the Financial Assistance Award.

No funds shall be paid directly to individuals benefiting from A&D 64 Services.

c. **Reporting Requirements**

See Exhibit E, 10.

d. Special Reporting Requirements

County shall prepare and electronically submit, to amhcontract.administrator@dhsoha.state.or.us, written quarterly summary reports on the delivery of A&D 64 Services no later than 45 calendar days following the end of each subject quarter for which financial assistance is awarded through this Agreement. Reports must be prepared using forms and procedures prescribed by OHA. Forms are located at http://www.oregon.gov/OHA/HSD/AMH/Pages/Reporting-Requirements.aspx.

Each report shall provide the following information:

(1) Information and data as required on the OHA-provided reporting template;

(2) Provide, for financial settlement purposes, the total amount expended during the subject quarter for the following:

(a) Amount expended for staff positions (Housing Coordination)

(b) Amount expended for administration.

(c) Amount expended for move-in and barrier removal services (Residential Costs);

(d) Amount expended for Rental Assistance and

(3) All required reports submitted must be complete and accurate to the satisfaction of OHA. If a report is found to be incomplete or not accurate, it will be returned for correction and resubmission. Failure to submit complete and accurate reports could result in the withholding of future payment of Financial Assistance.

e. Financial Assistance Calculation, Disbursement, and Confirmation of Performance and Reporting Requirements

See Exhibit D, Payment, Settlement, and Confirmation

Use Payment and Confirmation language.

7. **Service Name:** **INTOXICATED DRIVER PROGRAM FUND (IDPF)**

Service ID Code: **A&D 65**

a. **Service Description**

The Intoxicated Driver Program Fund (IDPF) supports the delivery of:

(1) Eligible Services to Individuals who have been adjudicated for Driving Under the Influence of Intoxicants (DUII) or Minor in Possession (MIP); and

(2) Special Services provided for individuals adjudicated for DUII.

Definitions

(1) "Eligible Individual" means an Individual who:

(a) Is not eligible for Medicaid or is underinsured; and

(b) Demonstrates a need for financial assistance based on an income below 200% of the federal poverty guidelines.

(2) "Information programs" means educational services for Individuals who have been adjudicated for an MIP, and do not meet diagnostic criteria for a substance use disorder.

(3) "Treatment" means medically appropriate services for Individuals diagnosed with a substance use disorder

b. **Performance Requirements**

(1) Providers of Services funded through this Agreement must have a current Certificate and accompanying letter issued by OHA in accordance with OAR 309-008-0100 through 309-008-1600, as such rules may be revised from time to time.

(2) DUII services providers funded through this Agreement must meet and comply with the program standards set forth in OAR 309-019-0195, as such rules may be revised from time to time.

(3) Eligible Services are limited to:

(a) Providing treatment for Eligible Individuals who enter diversion agreements for DUII under ORS 813.200; or

(b) Providing treatment for Eligible Individuals convicted of DUII as required under ORS 813.021; or

(c) Providing treatment or information programs for Eligible Individuals convicted of MIP as required under ORS 471.432.

(4) Special Services funded through this Agreement are for Individuals who enter a diversion agreement for or are convicted of DUII whether they are an Eligible Individual or not. Special Services are limited to:

(a) Services required to enable an Individual with a disability to participate in treatment at a Division approved DUII services provider as required by ORS 813.021 or ORS 813.200; or

(b) Services required to enable an Individual whose proficiency in the use of English is limited because of the person's national origin to participate in treatment at a Division approved DUII services provider as required by ORS 813.021 or ORS 813.200.

(c) Services may only be due to the Individual's disability or limited proficiency in the use of English.

(5) OHA will follow the Medicaid fee schedule in making disbursements for Eligible Services. At no time will OHA provide financial assistance above the Medicaid fee schedule for Eligible Services.

(6) For Special Services, OHA will make disbursements based on the County's actual cost up to $500 per Individual. To receive payment for Special Services costs exceeding $500 per Individual, County must obtain OHA's approval of the Special Services prior to incurring such costs.

c. **Reporting Requirements**

See Exhibit E, 10.

d. **Special Reporting Requirements**

(1) County shall prepare and electronically submit, to amhcontract.administrator@dhsoha.state.or.us, written quarterly summary reports on the delivery of IDPF Services, no later than 45 calendar days following the end of each subject quarter for which financial assistance is awarded through this Agreement. Reports must be prepared using forms and procedures prescribed by OHA. Forms are located at http://www.oregon.gov/OHA/HSD/AMH/Pages/Reporting-Requirements.aspx.

(2) County is responsible for documenting consent for disclosure compliant with 42 CFR Part 2 as necessary to comply with the reporting requirements in this section.

e. **Financial Assistance Calculation, Disbursement, and Confirmation of Performance and Reporting Requirements Procedures**

See Exhibit D, Payment, Settlement, and Confirmation Requirements

Use Payment and Confirmation language.

8. Service Name: **COMMUNITY BEHAVIORAL AND SUBSTANCE USE DISORDER SERVICES**

Service ID Code: **A&D 66**

a. Service Description

(1) Community Behavioral and Substance Use Disorder Services (A&D 66 Services) are Services delivered to youth and adults with Substance Use Disorders or to youth and adults with co-occurring substance use and mental health disorders. These Services shall be provided to Individuals who are not eligible for the Oregon Health Plan (OHP) or who otherwise do not have a benefit that covers the A&D 66 Services described in this Service Description.

The purpose of A&D 66 Services is to build upon resilience, assist Individuals to make healthier lifestyle choices, and to promote recovery from Substance Use Disorders. A&D 66 Services consist of outreach (case finding), early identification and screening, assessment and diagnosis, initiation and engagement, therapeutic interventions, continuity of care, recovery management, and Interim Services.

(2) It is required that pregnant women receive Interim Services within 48 hours after being placed on a waitlist. At a minimum, 45 CFR §96.121 requires that Interim Services include the following:

(a) Counseling and education about HIV and tuberculosis (TB);

(b) Risks of sharing needles;

(c) Risks of transmission to sexual partners and infants;

(d) Steps to ensure that HIV and TB transmission does not occur;

(e) Referral for HIV or TB treatment services, if necessary;

(f) Counseling on the effects of alcohol and drug use on the fetus; and

(g) Referral for prenatal care.

(3) A&D 66 Services must be evidence-based or promising practices. Services may be reduced commensurate with reductions in funding by OHA. County shall provide the following Services, subject to availability of funds:

(a) Outreach (case finding), early identification and screening, assessment and diagnosis, and education:

A. Outreach: Partner with healthcare Providers and other social service partners who provide screening for the presence of behavioral health conditions to facilitate access to appropriate Services.

B. Early Identification and Screening: Conduct periodic and systematic screening that identify Individuals with behavioral health conditions and potential physical health consequences of behavioral health conditions which consider epidemiological and community factors, as identified in the

Local Plan or Regional Health Improvement Plan (RHIP) as applicable.

C. Assessment and Diagnosis: Perform multidimensional, biopsychosocial assessments as appropriate based on OAR 309-018-0140 to guide person-centered services and supports planning for behavioral health and co-existing physical health conditions. Identify Individuals who need intensive care coordination. Use the following standardized protocols and tools to identify the level of Service need and intensity of care and coordination, addressing salient characteristics such as age, culture, and language:

I. American Society of Addiction Medicine (ASAM) for Individuals receiving Substance Use Disorder Services.

II. Level of Care Utilization System (LOCUS) for adults transitioning between the state hospitals, licensed mental health residential services, and Intensive Community Services. **"Intensive Community Services"** are defined as assertive community treatment, intensive case management, and supported or supportive housing.

III. Level of Service Intensity Determination for children including use of Child and Adolescent Service Intensity Instrument (CASII) and Early Childhood Service Intensity Instrument (ECSII) for children receiving services with "Intensive Outpatient Services and Supports" or "Intensive Treatment Services," as defined in OAR 309-022-0105(43) and 309-022-0105(44), respectively.

D. Education: Partner with other community groups and organizations, including but not limited to schools, community corrections, and other related organizations, to perform education and outreach to potentially at-risk populations for alcohol and drug abuse in order to educate those groups around substance abuse treatment and recovery topics tailored to the individual groups' needs, in order to educate the broader community on these issues as well as begin the process of promoting potential initiation and engagement in treatment Services within these populations.

(b) Initiation and Engagement: Promote initiation and engagement of Individuals receiving Services and supports, which may include but are not limited to:

A. Brief motivational counseling;

B. Supportive Services to facilitate participation in ongoing treatment; and

C. Withdrawal management for Substance Use Disorders and supportive pharmacotherapy to manage symptoms and adverse consequences of withdrawal following assessment.

(c) Therapeutic Interventions:

General community-based Services, which may include:

A. Condition management and a whole person approach to single or multiple chronic conditions based on goals and needs identified by the Individual;

B. General outpatient Services;

C. Medication management for:

I. Mental health disorders (when providing Services for Individuals with co-occurring mental and Substance Use Disorders).

II. Substance Use Disorders:

(A) Includes pharmacotherapy for adults diagnosed with opioid dependence, alcohol dependence, or nicotine dependence and without medical contraindications. Publicly funded programs will not discriminate in providing access to Services for Individuals using medications to treat and manage addictions.

(B) Pharmacotherapy, if prescribed, should be provided in addition to and directly linked with psychosocial treatment and support.

D. Detoxification for Individuals with Substance Use Disorders under OAR 415-050-0000 through 415-050-0095. Supportive pharmacotherapy may be provided to manage the symptoms and adverse consequences of withdrawal, based on a systematic assessment of symptoms and risk of serious adverse consequences related to the withdrawal process; and

E. Meaningful Individual and family involvement.

(d) Continuity of Care and Recovery Management:

A. Continuity of care Services includes:

I. Coordinate and facilitate access to appropriate housing Services and community supports in the Individual's community of choice;

II. Facilitate access to appropriate levels of care and coordinate management of Services and supports based on an Individual's needs in their community of choice;

III. Facilitate access to Services and supports provided in the community and Individual's home designed to

assist children and adults with Substance Use Disorders whose ability to function in the community is limited and for whom there is significant risk of higher level of care needed; and

IV. Coordinate with other agencies to provide intensive care coordination sufficient to help Individuals prevent placement in a more restrictive level of care and to be successfully served in their community of choice.

B. Recovery Management Services includes:

I. Continuous case management;

II. Monitoring of conditions and ongoing recovery and stabilization;

III. Individual and family engagement, including provision of child care for parents actively involved in any of these treatment, education, outreach, or recovery support Services; and

IV. Transition planning that addresses the Individual's needs and goals.

b. **Performance Requirements**

(1) A Provider delivering A&D 66 Services with funds provided through this Agreement may not use funds to deliver covered Services to any Individual enrolled in the Oregon Health Plan.

(2) The quality of A&D 66 Services supported with funds provided through this Agreement will be measured in accordance with the criteria set forth below. These criteria are applied on a countywide basis each calendar quarter (or potion thereof) during the period for which the funds are awarded through this Agreement. County shall develop and implement quality assurance and quality improvement processes to improve progressively, as measured by the criteria set forth below, the quality of Services supported with funds provided through this Agreement. OHA may assign performance payments to some or all of these standards and measures and may recommend additional actions to improve quality.

(a) **Access**: Access is measured by OHA as the percentage of residents estimated by OHA surveys to need treatment who are enrolled in A&D 66 Services.

(b) **Treatment Service Initiation**: Treatment service initiation is measured as the percentage of Individuals served within 14 calendar days of their original assessment, also known as the index date. The index date is a start date with no Services in the prior 60 days.

(c) **Utilization**: Utilization requirements for Individuals receiving continuum of care services (non-detox) will be identified in a Special Condition, subject to a particular line in Exhibit C, "Financial Assistance Award."

(d) **Engagement**: Engagement is measured by OHA as the percentage of Individuals receiving A&D 66 Services under this Agreement who enter treatment following positive assessment.

(e) **Treatment Service Retention**: Treatment Service retention is measured by OHA as the percentage of Individuals receiving A&D 66 Services under this Agreement who are actively engaged in treatment for 90 consecutive days or more.

(f) **Reduced Use**: Reduced use is measured by OHA as the percentage of Individuals engaged in and receiving A&D 66 Services under this Agreement who reduce their use of alcohol or other drugs during treatment, as reported in the MOTS data system, upon planned interruption in Services or 90 day retention, whichever comes first.

(g) **Completion**: Completion is measured as the percentage of Individuals engaged in and receiving A&D 66 Services under this Agreement who complete two thirds of their treatment plan and are engaged in recovery support or services at the time treatment Services are terminated. Providers of A&D 66 Services funded through this Agreement must participate in client outcome studies conducted by OHA.

(h) **Facility-Based Care Follow-Up**: Facility-based care follow-up is measured by the percentage of Individuals with a follow-up visit completed within 7 calendar days after: (A) hospitalization for mental illness; or (B) any facility-based Service defined as residential.

(i) **Hospital and Facility-Based Readmission rates**: Hospital and facility-based readmission rates are measured by the number of Individuals returning to the same or higher levels of care within 30 and 180 calendar days against the total number of discharges.

(j) **Parent-Child Reunification**: Parent-child reunification is measured by the number of parents reunited with their child (or multiple children) against the number of parents served who have children in an out-of-home placement or foster care due to the Department of Human Service, Child Welfare Program's involvement.

(k) **Functional Outcomes - Housing Status; Employment Status; School Performance; Criminal Justice Involvement**: The 4 functional outcome measures that will be monitored by OHA and reported to the County are as follows:

A. Housing Status: If improved housing status is a goal of treatment or an Individual is homeless or in a licensed care facility, this measure will be monitored. This measure is defined as the number of Individuals who improve housing status as indicated by a change from homelessness or licensed facility-based care to private housing against the total number of Individuals with a goal to improve housing.

B. Employment Status: If employment is a goal of treatment, this measure will be monitored. This measure is defined as

the number of Individuals who become employed, as indicated by a change in employment status, against the number of Individuals with a goal of becoming employed.

C. School Performance: If school attendance is a goal of treatment, this measure will be monitored. The measure is defined as the number of Individuals who improve attendance in school while in active treatment against the total number of Individuals with a goal of improved attendance in school.

D. Criminal Justice Involvement: This measure will be monitored by OHA for Individuals referred for Services by the justice system. The measure is defined as the number of Individuals who were not arrested after 1 day or more of active treatment or 2 consecutive quarters (whichever comes first) against the total number of Individuals referred for Services by the justice system.

c. Reporting Requirements

See Exhibit E, 10.

d. Special Reporting Requirements

(1) Reports must be prepared using forms and procedures prescribed by OHA. Forms are located at http://www.oregon.gov/OHA/HSD/AMH/Pages/Reporting-Requirements.aspx.

(2) County shall prepare and electronically submit to amhcontract.administrator@dhsoha.state.or.us written quarterly summary reports on the delivery of A&D 66 Services, no later than 45 calendar days following the end of each subject quarter for which financial assistance is awarded through this Agreement.

(3) Each report shall provide the following information:

Description of the delivery of A&D 66 Services provided to individuals who are not enrolled in MOTS at the time of their participation in Prevention, Education, or Outreach Service delivery, as described in this Service Description. Cases without evidence of treatment engagement in the clinical record do not count toward the Service delivery requirement, except as listed above for Prevention, Education, and Outreach.

e. Financial Assistance Calculation, Disbursement, and Agreement Settlement Procedures

See Exhibit D, Payment, Settlement, and Confirmation Requirements

Use Payment and Settlement language.

9. **Service Name:** **SUBSTANCE USE DISORDER RESIDENTIAL & DAY TREATMENT CAPACITY**

Service ID Code: **A&D 67**

a. **Service Description**

Substance Use Disorder (SUD) Residential and Day Treatment Capacity (A&D 67) is for housing/lodging services for indigent, underfunded, or Medicaid-eligible Individuals who are enrolled in SUD adult or youth residential services or day treatment services where housing/lodging services are provided. A&D 67 Services provide a structured environment for an Individual on a 24-hour basis consistent with Level II and Level III of the American Society of Addiction Medicine (ASAM) patient placement criteria and transfer and continuity of care set forth in OAR 309-018-0135 through 309-018-0155 and 309-019-0135 through 309-019-0140, as such rules may be revised from time to time, are appropriate to the Individual's needs and include housing and food services.

Housing/lodging services includes;

(1) Bed with a frame and clean mattress;

(2) Pillow(s);

(3) Linens; sheets, pillowcases, and blankets;

(4) Bath towel and wash cloth;

(5) Private dresser or similar storage area for personal belongings;

(6) Meals: at least three meals must be provided daily in adequate amounts for each resident at each meal, as well as two snacks daily (may be subsidized with SNAP benefits);

(7) Laundry services at least weekly for personal clothing, linens, bath towel, and wash cloth; and

(8) Rent/Utilities (no additional charges to Individual while in treatment).

b. **Performance Requirements**

Providers of A&D 67 Services funded through this Agreement must comply with OAR 309-018-0100 through 309-018-0215 and OAR 309-019-0100 through 309-019-0220, as such rules may be revised from time to time. Providers of A&D 67 Services funded through this Agreement must also have a current approval or license issued by OHA in accordance with OAR 415-012-0000 through 415-012-0090 and must participate in client outcome studies conducted by OHA.

c. **Reporting Requirements**

See Exhibit E, 10.

d. **Financial Assistance Calculation, Disbursement, and Confirmation of Performance and Reporting Requirements Procedures**

See Exhibit D, Payment, Settlement, and Confirmation Requirements.

Use Payment and Confirmation language.

10. **Service Name:** **PROBLEM GAMBLING PREVENTION SERVICES**

Service ID Code: **A&D 80**

a. **Service Description**

(1) Problem Gambling Prevention Services (A&D 80 Services) are designed to meet the following objectives:

(a) Education aimed at increasing general public awareness of Problem Gambling that includes all populations of the general public; and

(b) Prevent Problem Gambling.

(2) The goals and outcomes for County's A&D 80 Services must be described in County's OHA approved Problem Gambling Prevention Implementation Plan, completed using the form located at:https://www.oregon.gov/oha/HSD/Problem-Gambling/Pages/Prevention.aspx; and submitted electronically to OHA at: amhcontractadministrator@dhsoha.state.or.us. County's A&D 80 Services will be monitored and evaluated on the basis of the County's effectiveness in achieving the goals and outcomes identified in the OHA approved County Problem Gambling Prevention Implementation Plan and through the Problem Gambling Prevention Data Collection System at: https//www.oregon.gov/oha/HSD/Problem-Gambling/Pages/Prevention.aspx.

b. **Performance Requirements**

(1) County shall designate a problem gambling prevention coordinator, who is qualified by virtue of knowledge, training, experience and skills, who shall be responsible for:

(a) Implementation plan development, utilizing a comprehensive planning framework for addressing awareness of problem gambling and prevention education. Planning frameworks shall demonstrate the following: assessment of current status of the problem, desired outcome, strategic plan to meet outcome; and evaluation plan;

(b) Utilizing community assessment to identify trackable outcome measurements within implementation plan;

(c) Implementing problem gambling prevention activites each quarter related to their identified goals in their implementation plan, unless preauthorized by OHA Problem Gambling Prevention Services Specialist;

(d) Monitoring, implementation, evaluation and oversite of the Problem Gambling Prevention Implementation Plan in accordance with the "Special Reporting Requirements" section below and submitting it electronically to OHA through the Problem Gambling Prevention Data Collections System at https://www.oregon.gov/oha/HSD/Problem-Gambling/Pages/Prevention.aspx;

(e) Preparation of reports, as described in the "Special Reporting Requirements" section below;

(f) Oversight and coordination of A&D 80 Services, activities, and programs provided in the County;

(g) Completion of Problem Gambling Prevention Coordinator Training Series requirements within two years from the date of hire. The Problem Gambling Prevention Coordinator Training Series requirements are located at https://www.oregon.gov/oha/HSD/PRoblem-Gambling/Pges/Prevention.aspx;

(h) Attend a minimum of 15 hours of OHA Problem Gambling Services approved trainings per biennium, separate from the Problem Gambling Prevention Coordinator Training Series referenced above;

(i) Development and adoption of a comprehensive written policy, on gambling in the workplace; and.

(j) Participate in a miniumn of one Technical Assistance/Program Development visit in a three year period. Technical Assistance Visit Toolkit and Schedule for visit, located at:https://www.oregon.gov/oha/HSD/Problem-Gambling/Pages/Prevention.aspx.

(2) In accordance with OHA's Trauma Informed Care (TIC) Policy, as described in Exhibit D, "Special Terms and Conditions," County's CMHP providing A&D 80 Services shall have: a TIC plan; TIC as a core principle in CMHP's policies, mission statement, and written program/service information; initiated and completed an agency self-assessment; and a quality assurance structure/process to further develop and sustain TIC.

(3) The Problem Gambling Prevention Implementation Plan shall include details of the Services to be provided by County and must include as many of the Six Center for Substance Abuse Prevention (CSAP) Strategies as possible (e.g. Prevention Education, Information Dissemination, Community Based Processes, Problem Identification and Referral, Alternative Activities, and Environmental Strategies). The Six CSAP Strategies with Examples may be found at: https://www.oregon.gov/oha/HSD/Problem-Gambling/Pages/Prevention.aspx.

County shall not spend greater than 25% of their total allocation on the purchase of a product or supply unless preauthorized by OHA Problem Gambling Prevention Specialist. Problem Gambling Prevention funds are intended to support FTE for the integration and direct service of problem gambling prevention services.

The financial assistance awarded to County for A&D 80 Services in the subsequent contracting period will, in part, depend upon achievement of the goals and outcomes set forth in the County's Problem Gambling Prevention Implementation Plan. In the event of a conflict or inconsistency between the provisions of the County's Problem Gambling Prevention Implementation Plan and provisions of this Service Description, the provisions of this Service Description shall control.

Providers of A&D 80 Services must implement A&D 80 Services funded through this Agreement in accordance with the County's current Problem Gambling Prevention Implementation Plan.

c. Special Reporting Requirements

(1) All A&D 80 Services provided by County under this Agreement must be reported and submitted electronically to OHA on a quarterly basis through the Oregon Problem Gambling Prevention Data Collection System, located at https://www.oregon.gov/oha/HSD/Problem-Gambling/Pages/Prevention.aspx, no later than 45 calendar days following the end of each quarter November, February, May, and August, with respect to Services provided in the prior quarter.

(2) Trauma Informed Care (TIC): County shall submit a written report related to trauma informed care activities, process or needs to OHA upon request.

(3) County shall notify OHA Statewide Problem Gambling Prevention and Outreach Specialist within 10 business of any changes related to designated Problem Gambling A&D 80 Services program staff. Notification shall be sent to pgs.support@dhsoha.state.or.us.

d. Financial Assistance Calculation, Disbursement, and Confirmation of Performance and Reporting Requirements Procedures

See Exhibit D, Payment, Settlement, and Confirmation Requirements.

Use Payment and Confirmation language.

11. **Service Name:** **PROBLEM GAMBLING TREATMENT SERVICES**
Service ID Code: **A&D 81**

a. Service Description

(1) For purposes of this A&D 81 Service Description, an Individual must have one of the diagnoses listed below in order to obtain services and the diagnosis must be primary or secondary.

(a) A diagnosis of Gambling Disorder, defined as an Individual with persistent and recurrent problematic gambling behavior leading to:

i. clinically significant impairment or distress, as indicated by the Individual exhibiting one or more diagnostic criteria of the most current version of the Diagnostic and Statistical Manual for Mental Disorders; or

(b) A diagnosis of relationship distress with spouse or intimate partner; a diagnosis of relational problems or problems related to psychosocial circumstances; or diagnosis of stressful life events affecting family and household, as listed within the most current version of the International Classification of Disease (ICD), as it relates to problem gambling.

(2) Problem Gambling Treatment Services (A&D 81 Services) are as follows:

(a) Outpatient A&D 81 Services provide problem gambling assessment, treatment, and rehabilitation services, delivered on an outpatient basis or intensive outpatient basis to Individuals and those in relationships with Individuals with gambling related problems who are not in need of 24-hour supervision for effective treatment. Outpatient A&D 81 Services must include regularly scheduled face-to-face or non-face-to-face therapeutic sessions or services, in response to crisis for the Individual, and may include individual, group, couple, and family counseling.

(b) "Session" or "treatment session" means A&D 81 Services delivered in individual, couple, family, or group formats. Treatment sessions must be reported by type (e.g., individual, couple, family, or group) and length (time).

(c) Client-finding/referral pathway development and maintenance: Treatment-specific outreach is targeted outreach for which the primary purpose is to get disordered and problem gamblers and, if appropriate, their family members into treatment through screening, identification and referrals from entities such as social service, allied health, behavioral health and criminal justice organizations.

(d) In reach activities: Treatment-specific efforts that engage, educate and assist behavioral health programs and/or SUD's treatment programs within County or subcontractors with screening, identification and referral to A&D 81 Services.

(e) A&D 81 Services are to be made available to any Oregon resident with a Gambling Disorder or diagnosis of relational problem as defined above. A&D 81 Services to out-of-state residents are permissible if the presenting Gambling Disorder or relational problem diagnoses are reported as primarily related to an Oregon Lottery product. Providers must request a waiver, to provide Services to out of state residents, using the Out of State Variance Form, located at: https://www.oregon.gov/oha/hsd/problem-gambling/pages/Data-Entry.aspx, and submitting the request to OHA electronically at the email address provided on the form.

b. Performance Requirements

(1) County shall maintain Certification, as provided under OAR 309-008-0100 through 309-008-1600 "Certification of Behavioral Health Treatment Services," for all levels of outpatient treatment in accordance with OAR 309-019-0100 through 309-019-0220 "Outpatient Behavioral Health Services," as such rules may be revised from time to time.

(2) County shall meet the performance requirements, which are imposed and assessed on an individual County basis, listed below. If OHA determines that a Provider of A&D 81 Services fails to meet any of the performance requirements, the specific performance requirements that are out of compliance will be reviewed at a specifically scheduled performance requirement site review or OHA may reduce the monthly allotments based on under-used allotments identified through the OHA approved problem gambling treatment data collection system or other required reports in accordance with the "Special Reporting Requirements" section below.

The performance requirements for A&D 81 Services are as follows:

(a) **Access**: The amount of time between an Individual with a Gambling Disorder requesting A&D 81 Services and the first offered service appointment must be 5 business days or less for at least [90%] of all Individuals receiving A&D 81 Services funded through this Agreement.

(b) **Client Satisfaction**: The percent of Individuals receiving A&D 81 Services who have completed a problem gambling client satisfaction survey and would positively recommend the Provider to others must not be less than [85%.] Client satisfaction surveys must be completed by no less than [50%]of total enrollments.

(c) **Long-term Outcome**: At the 6-month follow up for Individuals completing treatment, a minimum of [50%] must report abstinence or reduced gambling.

(d) **Retention**: The percent of Individuals receiving A&D 81 Services who actively engage in treatment for at least 10 clinical sessions must be at least [40%].

(e) **Successful Completion**: The percent of all Individuals receiving A&D 81 Services who successfully complete treatment must be at least [35%] (unadjusted rate). Successful completion of problem gambling treatment is defined as Individuals who have: (a) achieved at least [75%] of short-term treatment goals; (b) completed a continued wellness plan (i.e., relapse prevention plan); and (c) lack of engagement in problem gambling behaviors for at least [30] consecutive days prior to successful completion of A&D 81 Services.

(f) **Client Enrollment Survey Completion**: The percent of Individuals receiving A&D 81 Services who complete a client enrollment survey must not be less than [95%.]

(g) **Accordance with OHA Trauma Informed Care (TIC) Policy**: County's CMHP providing A&D 81 Services shall have a TIC plan and have TIC appear as a core principle in CMHP's policies, mission statement, and written program/service information. County's CMHP shall have initiated and completed an agency self-assessment and have a quality assurance structure/process to further develop and sustain TIC.

(3) **Technical Assistance and Program Development**

(a) Program shall participate in a minimum of one Technical Assistance/Program Development visit in a three year period. Schedule of visit, located at: https://www.oregon.gov/oha/HSD/Problem-Gambling/Pages/Treatment.aspx.

(b) Process/procedure and reporting guidelines for Technical Assistance and Program Development visit is located at: https://www.oregon.gov/oha/HSD/Problem-Gambling/Pages/Treatment.aspx.

(c) County shall provide problem gambling in-reach efforts within their A&D 81 Service organization. This should include engagement, education, screening, identification and referrals to A&D 81 Services using a Gambling Screening, Brief Intervention, and Referral to Treatment (GBIRT) type model, which can be found at: https://www.oregon.gov/oha/HSD/Problem-Gambling/Pages/Treatment.aspx.

(d) A&D 81 Services are limited to [12] months per Individual. This Service limitation will count [12] consecutive months, starting with the Individual's enrollment date. Individuals must have been out of Service for a minimum of [90] consecutive days prior to any re-enrollment in the state system.

Providers may request a waiver of the [12] month Service limitation by completing the Length of Stay Variance Form, located at:https://www.oregon.gov/oha/hsd/problem-gambling/pages/Data-Entry.aspx, and submitting the form to OHA electronically at the email address provided on the form. The request for a waiver must

be received no less than 30 calendar days prior to exceeding the [12] month Service limitation period and shall include the clinical need for a waiver and a treatment plan indicating the requested length of time to complete the plan. Waivers, if approved, will be for fixed periods of time.

c. Continuing care or aftercare is limited to [12] months per Individual and provided upon successful completion of gambling treatment Services. This Service limitation will continue [12] consecutive months starting with the Individual's termination or discharge date. Special Reporting Requirements

County shall notify OHA Problem Gambling Treatment and Recovery Specialist within 10 business days of any changes related to designated Problem Gambling A&D 81 Services program staff. Notification shall be sent to pgs.support@dhsoha.state.or.us.

County shall submit the following information to OHA regarding Individuals receiving A&D 81 Services. Information to be submitted to OHA/PGS management information system provider. All Providers of A&D 81 Services shall comply with the current OHA designated and approved problem gambling treatment data collection system and manual located at https://www.oregon.gov/oha/hsd/problem-gambling/pages/Data-Entry.aspx.

(1) Intake Data: The enrollment record abstracting form and the gambling client survey must be collected and submitted within [14] calendar days of the first face-to-face treatment contact with an Individual.

(2) Client Consent Form: A completed client consent form to participate in evaluation follow-up efforts must be collected and submitted prior to Service conclusion. Client refusal to participate in the follow-up survey must be documented in the client file.

(3) Encounter Data Reporting Requirements: All Providers of A&D 81 Services funded through this Agreement must submit Individual-level, Service delivery activity (encounter data) within 30 calendar days following the end of each month.

Encounter data must be submitted electronically utilizing the HIPAA approved "837" format. Files transferred over non-secure web or Internet must be encrypted utilizing an encryption format approved by OHA. The subject line for each electronic transmission of data must include the program name, the month covered by the submission (e.g. August 2020), and the words "Gambling Encounter Data."

Counties with secure web services may post the data to their server, using the same naming convention described above, provided that OHA has access and receives timely notification.

Prior to submitting data, each encounter claim must be documented in the clinical record and must include the date of the encounter Service, type of Service rendered, time of Service, length of Service, setting of Services, personnel rendering Services (including their name, credentials and signature),, and a clinical note that includes a description of the session .

Providers are expected to reconcile encounter data reports and correct any errors within 30 calendar days of receipt of encounter data report from OHA's management information system provider. Discrepancies must include apparent cause and remedy. Adjustments will be carried forward to the next month within the effective period of this Agreement.

(4) Discharge Data: Discharge data must be collected and submitted within [90] calendar days after the last date of Service to an Individual.

(5) Trauma Informed Care (TIC): County shall submit a written report related to trauma informed care activities, process, or needs to OHA upon request.

(4) Financial Assistance Calculation, Disbursement, Confirmation of Performance and Reporting Requirements, & Provider Audit Procedures

See Exhibit D, Payment, Settlement, and Confirmation Requirements.

Use Payment and Confirmation language.

In addition:

(a) OHA will provide financial assistance for A&D 81 Services identified in a particular line of Exhibit C, "Financial Assistance Award," as specified in the PGS Procedure Codes and Rates for Treatment Providers rate sheet, located at https://www.oregon.gov/oha/HSD/Problem-Gambling/Pages/Treatment.aspx, as it may be revised from time to time.

(b) OHA will not make multiple financial assistance disbursements for a single clinical activity, except for group therapy. For example, OHA will not provide financial assistance for an individual treatment session for both an Individual and his or her spouse when the treatment was delivered in a single marital session.

(c) Providers of A&D 81 Services shall not charge Individuals whose Services are paid through this Agreement any co-pay or other fees for such Services.

(d) Provider Audits: Providers receiving funds under this Agreement, for A&D 81 Services, are subject to audits of all funds applicable to A&D 81 Services rendered. The purpose of these audits is to:

i. Require proper disbursements were made for covered A&D 81 Services;

ii. Recover over-payments;

iii. Discover any potential or actual instances of fraud and abuse; and

iv. Verify that encounter data submissions are documented in the client file, as required and described in the "Special Reporting Requirements" above.

Providers may be subject to OAR 407-120-1505 "Provider and Contractor Audits, Appeals, and Post Payment Recovery," and OAR 410-120-1510 "Fraud and Abuse," as such rules may be revised from time to time.

(e) OHA's obligation to provide assistance under this Agreement is subject to the satisfaction of the County delivering the anticipated level of A&D 81 Services, upon which the allotments were calculated. If, for a period of 3 consecutive months during the term of this Agreement, County delivers less than the anticipated level of Services, upon which allotments were calculated in a particular line of Exhibit C, "Financial Assistance Award," OHA may amend the amount of funds awarded for A&D 81 Services in proportion to the under-utilization during that period, including but not limited to reducing the amount of future funds awarded for A&D 81 Services in an amount equal to funds reduced under that line of the Financial Assistance Award for under-utilization. An amendment shall be prepared and executed between OHA and County to reflect this reduction.

12. **Service Name:** **PROBLEM GAMBLING RESIDENTIAL SERVICES**
Service ID Code: **A&D 82**

a. **Service Description**

For purposes of this A&D 82 Service Description, an Individual with a Gambling Disorder is an Individual with persistent and recurrent problematic gambling behavior leading to clinically significant impairment or distress, as indicated by the Individual meeting the diagnostic criteria of the most current version of the Diagnostic and Statistical Manual for Mental Disorders. This diagnosis must be primary or secondary.

(1) Problem Gambling Residential Services (A&D 82 Services) are Services that provide problem gambling assessment, treatment, rehabilitation, and 24-hour observation monitoring for Individuals with a Gambling Disorder.

(2) Referral to A&D 82 Services is through an approved A&D 81 Problem Gambling Treatment Outpatient Service provider or Emergency Department, with specific approval of the A&D 82 Service provider.

(3) A&D 82 Services are to be made available to any Oregon resident with a Gambling Disorder, as defined above. A&D 82 Services to out-of-state residents are permissible if the presenting Gambling Disorder is reported as primarily related to an Oregon Lottery product.

b. **Performance Requirements**

(1) County shall maintain a License as provided under OAR 415-012-0000 through 415-012-0090, "Licensure of Substance Use Disorder and Problem Gambling Residential Treatment and Recovery Services," and provide gambling treatment residential services, in accordance with OAR 309-018-0100 through 309-018-0215 "Residential Substance Use Disorders and Problem Gambling Treatment and Recovery Services," as such rules may be revised from time to time.

(2) County shall meet the performance standards, which are imposed and assessed on an individual County basis, listed below. If OHA determines that a Provider of A&D 82 Services fails to meet any of the performance standards, the specific performance standards that are out of compliance will be reviewed at a specifically scheduled performance standards site review or OHA may reduce the monthly allotments based on under-used allotments identified through the OHA approved problem gambling treatment data collection system or other required reports in accordance with the "Special Reporting Requirements" section below.

(a) **Access**: The amount of time between an Individual with a Gambling Disorder requesting A&D 82 Services and the first offered service appointment must be 10 calendar days or less for at least [90%] of all Individuals receiving A&D 82 Services funded through this Agreement.

(b) **Client Satisfaction**: The percent of Individuals receiving A&D 82 Services who have completed a problem gambling client satisfaction survey and would positively recommend the Provider to others must

not be less than [85%.] Client satisfaction surveys must be completed by no less than [85%] of total enrollments.

(c) **Long-term Outcome**: At the 6-month follow up for Individuals completing treatment, a minimum of [50%] must report abstinence or reduced gambling.

(d) **Retention:** The percent of Individuals receiving A&D 82 Services who actively engaged in treatment for [25] or more consecutive days must be at least [40%].

(e) **Successful Completion**: The percent of all Individuals receiving A&D 82 Services who successfully complete treatment must be at least [70%.] Successful Completion of problem gambling treatment is defined as the Individuals who: (a) are stabilized to safely return to the community and have established contact with a treatment professional, including a scheduled appointment, in their local community for continuing care; (b) have achieved at least [75%]of short-term treatment goals; and (c) have completed a continued wellness plan (i.e. relapse prevention plan).

(f) **Client Enrollment Survey Completion**: The percent of Individuals receiving A&D 82 Services who complete a client enrollment survey must not be less than [95%.]

(g) **Accordance with OHA Trauma Informed Care (TIC) Policy**: County's CMHP providing A&D 82 services shall have a TIC plan and have TIC appear as a core principle in CMHP policies, mission statement, and written program/service information. County's CMHP shall have initiated and completed an agency self-assessment and have a quality assurance structure/process to further develop and sustain TIC.

(3) **Technical Assistance and Program Development**

(a) Program shall participate in a minimum of one Technical Assistance/Program Development visit in a three-year period. Schedule of visit, located at: https://www.oregon.gov/oha/HSD/Problem-Gambling/pages/Tretatment.aspx.

(b) Process/procedure and reporting guidelines for Technical Assistance and Program Development visit is located at: https://www.oregon.gov/oha/HSD/Problem-Gambling/Pages/Workforce.aspx.

c. **Special Reporting Requirements**

County shall notify OHA Problem Gambling Services Manager within 10 business days of any changes related to designated Problem Gambling A&D 82 Services program staff. Notification shall be sent to pgs.support@dhsoha.state.or.us
County shall submit the following information to OHA regarding Individuals receiving A&D 82 Services. Information to be submitted to~~,~~ OHA/PGS approved management information system. ~~n contractor~~. All Providers of A&D 82 Services shall comply with the current OHA designated and approved problem gambling treatment data collection system and manual, located at https://www.oregon.gov/oha/HSD/Problem-Gambling/Pages/Workforce.aspx.

(1) Intake Data: The enrollment record abstracting form and the gambling client survey must be collected and submitted within 14 calendar days of the first face-to-face treatment contact with an Individual.

(2) Client Consent Form: A completed client consent form to participate in evaluation follow-up efforts must be collected and submitted prior to Service conclusion. Client refusal to participate in the follow-up survey must be documented in the client file.

(3) Encounter Data Reporting Requirements: All Providers of A&D 82 Services funded through this Agreement must submit Individual-level, Service delivery activity (encounter data) within 30 calendar days following the end of each month.

Encounter data must be submitted electronically utilizing the HIPAA approved "837" format. Files transferred over non-secure web or Internet must be encrypted utilizing an encryption format approved by OHA. The subject line for each electronic transmission of data must include the program name, the month covered by the submission (i.e. August 2020) and the words "Gambling Encounter Data."

Counties with secure web services may post the data to their server, using the same naming convention described above, provided that OHA has access and receives timely notification.

Prior to submitting data, each encounter claim must be documented in the clinical record and must include the date of the encounter Service, type of Service rendered, time of Service, length of Service, setting of Service, personnel rendering Service (including their name, credentials and signature), and a clinical note that includes a description of the session.

Providers are expected to reconcile encounter data reports and correct any errors within 30 calendar days of receipt of encounter data report from OHA's management information system provider. Discrepancies must include apparent cause and remedy. Adjustments will be carried forward to the next month within the effective period of this Agreement.

(4) Discharge Data: Discharge data must be collected and submitted within 90 calendar days after the last date of Service to an Individual.

(5) Trauma Informed Care: County shall submit written report related to trauma informed care activities, process, or needs to OHA upon request.

d. Financial Assistance Calculation, Disbursement, Settlement, & Provider Audit Procedures

See Exhibit D, Payment, Settlement, and Confirmation Requirements.

Use Payment and Settlement language.

In addition:

(1) OHA will provide financial assistance for A&D 82 Services identified in a particular line of Exhibit C, "Financial Assistance Award," as specified in the PGS Procedure Codes and Rates for Treatment Providers rate sheet, located at http://www.oregonpgs.org/treatment/billing-codes-and-rates/, as it may be revised from time to time.

(2) Providers of A&D 82 Services shall not charge Individuals whose Services are paid through this Agreement any co-pay or other fees for such Services.

(3) Provider Audits: Providers receiving funds under this Agreement, for A&D 82 Services, are subject to audits of all funds applicable to A&D 82 Services rendered. The purpose of these audits is to:

(a) Require proper disbursements were made for covered A&D 82 Services;

(b) Recover over-payments;

(c) Discover any potential or actual instances of fraud and abuse; and

(d) Verify that encounter data submissions are documented in the client file, as required and described in the "Special Reporting Requirements" above.

Providers may be subject to OAR 407-120-1505 "Provider and Contractor Audits, Appeals, and Post Payment Recovery," and OAR 410-120-1510 "Fraud and Abuse," as such rules may be revised from time to time.

(4) OHA's obligation to provide assistance under this Agreement is subject to the satisfaction of the County delivering the anticipated level of A&D 82 Services, upon which the allotments were calculated. If, for a period of 3 consecutive months during the term of this Agreement, County delivers less than the anticipated level of Services, upon which allotments were calculated in a particular line of Exhibit C, "Financial Assistance Award," OHA may amend the amount of funds awarded for A&D 82 Services in proportion to the under-utilization during that period, including but not limited to reducing the amount of future funds awarded for A&D 82 Services in an amount equal to funds reduced under that line of the Financial Assistance Award for under-utilization. An amendment shall be prepared and executed between OHA and County to reflect this reduction.

13. **Service Name:** **PROBLEM GAMBLING RESPTE TREATMENT SERVICES**

Service ID Code: **A&D 83**

a. **Service Description**

For purposes of this A&D 83 Service Description, an Individual with a Gambling Disorder is an Individual with persistent and recurrent problematic gambling behavior leading to clinically significant impairment or distress, as indicated by the Individual meeting the diagnostic criteria of the most current version of the Diagnostic and Statistical Manual for Mental Disorders. This diagnosis must be primary or secondary.

Problem Gambling Respite Treatment Services (A&D 83 Services) are problem gambling treatment Services designed to supplement outpatient Problem Gambling Treatment Services (A&D 81 Services). A&D 83 Services are to be delivered to Individuals who have special needs in relation to A&D 81 Services, such as highly suicidal Individuals or Individuals with co-occurring psychiatric conditions.

(1) The specific A&D 83 Services that may be delivered with funds provided through this Agreement and directed at Individuals with problems related to a gambling disorder are as follows:

(a) Secure Residential Treatment Facility (1-14 days residential care at a psychiatric health care facility): Providers of this Service must have OHA approved, written policies and procedures for operating this Service, hold licensure and comply with OAR 309-035-0100 through 309-035-0225, "Residential Treatment Facilities and Residential Treatment Homes for Adults with Mental Health Disorders".

(b) Respite Care Service (1-14 days residential care at an alcohol and drug treatment facility): Providers of this Service must have:

i. OHA approved, written policies and procedures for operating this Service, hold licensure and comply with OAR 309-018-0100 through 309-018-0215 "Residential Substance Use Disorders and Problem Gambling Treatment and Recovery Services;" and

ii. A current license issued by the OHA in accordance with OAR 415-012-0000 through 415-012-0090 "Licensure of Substance Use Disorders and Problem Gambling Residential Treatment and Recovery Services."

(2) Referral to A&D 83 Services is through an approved A&D 81 Problem Gambling Treatment Outpatient Service provider or Emergency Department, with specific approval of the A&D 83 Service provider.

(3) A&D 83 Services are to be made available to any Oregon resident with a Gambling Disorder as defined above. A&D 83 Services provided to out of state residents are permissible if the presenting Gambling Disorder is reported as primarily related to an Oregon Lottery product.

b. Performance Requirements

County shall meet the performance requirements, which are imposed and assessed on an individual County basis, listed below. If OHA determines that a Provider of A&D 83 Services fails to meet any of the specified performance requirements, the specific performance requirements out of compliance will then be reviewed at a specifically scheduled performance standards site review or OHA may deny invoiced allotments based on insufficient data or performance requirements identified through the OHA approved problem gambling treatment data collection system or other required reports in accordance with the "Special Reporting Requirements" section below.

The performance requirements for A&D 83 Services are as follows:

(1) **Access**: The amount of time between an Individual with a Gambling Disorder requesting A&D 83 Services and the first offered service appointment must be 5 business days or less for at least [100]% of all Individuals receiving A&D 83 Services funded through this Agreement.

(2) **Successful Completion**: The percent of all Individuals receiving A&D 83 Services who successfully complete treatment must be at least [100]%. Successful completion of problem gambling treatment is defined as Individuals who: (a) are stabilized, to safely return to the community, and have established contact, including a scheduled appointment, with a treatment professional in their local community for continuing care; or (b) have been transferred to residential gambling treatment Services.

(3) **Client Enrollment Survey Completion**: The percent of Individuals receiving A&D 83 Services who complete a client enrollment survey must not be less than [95]%.

(4) **Accordance with OHA Trauma Informed Care (TIC) Policy**: County's CMHP providing A&D 83 Services shall have a TIC plan and have TIC appear as a core principle in CMHP's policies, mission statement, and written program/service information. County's CMHP shall have initiated and completed an agency self-assessment and have a quality assurance structure/process to further develop and sustain TIC.

(c) **Technical Assistance and Program Development**

(a) Program shall participate in a minimum of one Technical Assistance/Program Development visit in a three-year period. Schedule of visit, located at: https://www.oregon.gov/oha/HSD/Problem-Gambling/Pages/Treatment.aspx.

(b) Process/procedure and reporting guidelines for Technical Assistance and Program Development visit is located at:https://www.oregon.gov/oha/HSD/Problem-Gambling/Pages/Treatment.asx.

c. **Special Reporting Requirements**

County shall notify OHA Problem Gambling Services Manager within 10 business days of any changes related to designated Problem Gambling A&D 83 Services program staff. Notification shall be sent to pgs.support@dhsoha.state.or.us.

County shall submit the following information to OHA regarding Individuals receiving A&D 83 Services. Information to be submitted to OHA/PGS management information system provider. All Providers of A&D 83 Services shall comply with the current OHA approved problem gambling treatment data collections system. User Manual located at: https://www.oregon.gov/oha/HSD/Problem-Gambling/Pages/Workforce.aspx.

(1) Intake Data: The enrollment record abstracting form and the gambling client survey must be collected and submitted within 14 calendar days of the first face-to-face treatment contact with an Individual.

(2) Encounter Data Reporting Requirements: All Providers of A&D 83 Services funded through this Agreement must submit Individual-level, Service delivery activity (encounter data) within 30 calendar days following the end of each month.

Encounter data must be submitted electronically utilizing the HIPAA approved "837" format. Files to be transferred over non-secure web or Internet must be encrypted utilizing an encryption format approved by OHA. The subject line for each electronic transmission of data must include the program name, the month covered by the submission (i.e. August 2020), and the words "Gambling Encounter Data."

Counties with secure web services may post the data to their server, using the same naming convention described above, provided that OHA has access and receives timely notification.

Prior to submitting data, each encounter claim, must be documented in the clinical record and must include the date of the encounter Service, type of Service rendered, time of Service, length of Service, setting of Service, personnel rendering Services (including their name, credentials and signature), and a clinical note that includes a description of the session.

(3) Discharge Data: Discharge data must be collected and submitted within 90 calendar days after the last date of Service to an Individual.

(4) Trauma Informed Care (TIC): County shall submit a written report related to trauma informed care activities, process or needs to OHA upon request.

d. **Financial Assistance Calculation, Disbursement and Provider Audit Procedures**

See Exhibit D, Payment, Settlement, and Confirmation Requirements.

Use Payment and Settlement language.

In addition:

(1) OHA will provide financial assistance for A&D 82 Services identified in a particular line of Exhibit C, "Financial Assistance Award," as specified in

the PGS Procedure Codes and Rates for Treatment Providers rate sheet, located at https://www.oregon.gov/oha/HSD/Problem-Gambling/Pages/Treatment/aspx, as it may be revised from time to time.

(2) Providers of A&D 82 Services shall not charge Individuals whose Services are paid through this Agreement any co-pay or other fees for such Services.

(3) Provider Audits: Providers receiving funds under this Agreement, for A&D 82 Services, are subject to audits of all funds applicable to A&D 82 Services rendered. The purpose of these audits is to:

(a) Require proper disbursements were made for covered A&D 82 Services;

(b) Recover over-payments;

(c) Discover any potential or actual instances of fraud and abuse; and

(d) Verify that encounter data submissions are documented in the client file, as required and described in the "Special Reporting Requirements" above.

Providers may be subject to OAR 407-120-1505 "Provider and Contractor Audits, Appeals, and Post Payment Recovery," and OAR 410-120-1510 "Fraud and Abuse," as such rules may be revised from time to time.

14. **Service Name:** **PROBLEM GAMBLING, CLIENT INDING/REFERAL PATHWAYS OUTREACH SERVICES**

Service ID Code: **A&D 84**

a. **Service Description**

A&D 84 Services is defined as Specific Outreach with the primary purposes of getting problem gamblers and/or family members enrolled in Problem Gambling Outpatient Treatment Services (A&D 81 Services).

The specific A&D 84 Services that may be delivered with funds provided under this Agreement are as follows:

(1) Outreach aimed at increasing the number of clients receiving outpatient treatment services;

(2) Targets a specific vulnerable population;

(3) Involves repeated contact and the development of a relationship with another professional provider; and

(4) Increases the number of Individuals that are assessed and referred to County problem gambling treatment programs.

A&D 84 - Services may be delivered by problem gambling treatment or prevention professionals.

b. **Performance Requirements**

(1) County shall designate a Problem Gambling, Client Finding/Referral Pathways Outreach specialist, who shall be responsible for:

(a) Development and implementation of Biennial Problem Gambling, Client Finding/Referral Pathway Outreach Strategic Plan.

(b) Overseeing and coordinating A&D 84 Services provided in the County; and

(c) Preparing the quarterly and annual reports as described in the "Special Reporting Requirements" section below.

c. **Special Reporting Requirements**

County shall prepare and electronically submit, to amhcontract.administrator@dhsoha.state.or.us, written quarterly reports on the delivery of A&D 84 Services no later than 45 calendar days following the end of each subject quarter for which financial assistance is awarded through this Agreement. Reports must be prepared using forms and procedures prescribed by OHA. Forms are located at http://www.oregon.gov/OHA/HSD/AMH/Pages/Reporting-Requirements.aspx.

Each report shall provide the following information:

(1) Description of results in achieving the goals and outcomes set forth in the Biennial Problem Gambling, Client Finding/Referral Pathways Outreach Strategic Plan.

(2) Description of the activities, appraisal of activities, and expenses during the preceding quarter in providing A&D 84 Services.

County shall prepare and electronically submit, to amhcontract.administrator@dhsoha.state.or.us, written annual report on the delivery of A&D 84 Services no later than 45 calendar days following the end of each subject year for which financial assistance is awarded through this Agreement. Reports must be prepared using forms and procedures prescribed by OHA. Forms are located at http://www.oregon.gov/OHA/HSD/AMH/Pages/Reporting-Requirements.aspx.

d. **Financial Assistance Calculation, Disbursement, and Confirmation of Performance and Reporting Requirements Procedures**

See Exhibit E, Payment, Settlement, and Confirmation Requirements.

Use Payment and Confirmation language.

In addition:

Providers of A&D 82 Services shall not charge Individuals whose Services are paid through this Agreement any co-pay or other fees for such Services.

15. Service Name: **SYSTEM MANAGEMENT AND COORDINATION**
Service ID Code: MHS 01

a. **Service Description**

As identified in OAR 309-014-0010 the purpose of a Community Mental Health Program (CMHP) is to provide a system of appropriate, accessible, coordinated, effective, efficient safety net services to meet the mental health needs of the citizens of the community.

System Management and Coordination (MHS 01 Services) is the central management of a Mental Health Services system for which financial assistance is included in Exhibit C, "Financial Assistance Award," of this Agreement.

County shall establish and maintain a structure for meaningful system design and oversight that includes involvement by Individuals and families across all ages that have or are receiving Mental Health Services.

System design and oversight must include:

(1) Planning;

(2) Implementation;

(3) Monitoring;

(4) Documentation of Service delivery in compliance with state and federal requirements;

(5) Contract and subcontract negotiation and monitoring;

(6) Coordination with state hospital Services;

(7) Evaluation of Services and supports; and

(8) Involvement in activities that focus on:

(a) Resource allocation;

(b) Outcomes;

(c) Quality improvement; and

(d) Advisory councils.

b. **Performance Requirements**

County shall provide, but is not limited to, the following:

(1) In providing MHS 01 Services, County must comply with OAR 309-014-0000 through 309-014-0040, as such rules may be revised from time to time.

(2) Provide pre-commitment Services to include, but not limited to:

(a) A pre-commitment investigation of an Individual who has been placed on an emergency psychiatric hold or for whom two persons have petitioned the court for the Individual's commitment to OHA. The investigation may only be conducted by a Certified Mental Health Investigator (as established by OAR 309-033-0920) who has not provided to the Individual any crisis Services.

(b) The development of a treatment plan to:

i. Divert an Individual from a commitment hearing; or

ii. If the Individual is committed, to provide for the initial post-hearing care, custody, and treatment of the Individual.

(3) Assigning and placing a committed Individual in a treatment Service appropriate to the Individual's needs and monitoring the care, custody, and treatment of a committed Individual under County's jurisdiction whether the Individual is placed at an inpatient facility, on trial visit or outpatient commitment at an outpatient setting.

(4) Ensuring that all legal procedures are performed as required by statute and administrative rule.

(5) Investigate and report allegations of abuse regarding served Individuals and provide protective services to those Individuals to prevent further abuse. The investigation, reporting, and protective services must be completed in compliance with ORS 430.731 through 430.768 and OAR 407-045-0000 through 407-045-0955, as such statutes and rules may be revised from time to time.

c. **Special Reporting Requirements**

None.

d. **Financial Assistance Calculation, Disbursement, and Confirmation of Performance and Reporting Requirements Procedures**

See Exhibit D, Payment, Settlement, and Confirmation Requirements.

Use Payment and Confirmation language.

16. **Service Name:** **AID AND ASSIST CLIENT SERVICES**
Service ID Code: **MHS 04**

a. **Service Description**

MHS 04 – Aid and Assist Client Services provides Restoration Services and periodic assessment of a defendant's capacity to stand trial as required in ORS 161.370 while the defendant resides in the community. These Services are required to restore an Individual's ability to aid and assist in their own defense, before the Individual can stand trial. Primary population for community Restoration Services are Individuals who are unable to aid and assist in their own defense due to a primary "mental disease or defect" (substance abuse, personality disorders, and pedophilia may be co-morbid to the primary condition, but cannot be the primary drivers of the inability to aid and assist, in keeping with ORS 161.370) AND not found by the Court to be dangerous to self or others.

(1) Restoration Services include:

(a) Providing the Individual with the education necessary to best facilitate the Individual's return to capacity including, but not limited to:

i. Skills training regarding court room procedures, roles, language and potential outcomes of the court process;

ii. Incidental support (e.g. purchase of food, clothing, or transportation, etc.); and

iii. Linkages to benefits and community resources such as Supplemental Nutrition Assistance Program (SNAP), housing/shelter, Medicaid enrollment, and cash assistance.

(b) Coordination and consultation to the jurisdictional court or other designated agencies within the criminal justice system and Oregon State Hospital (OSH) while the Individual is residing in the community and in the process of being returned to capacity. Services include, but are not limited to:

i. Coordination of the periodic assessment of capacity to aid and assist with the appropriate court;

ii. Collaboration and coordination with community corrections;

iii. Consultation to the County Mental Health Court, if Mental Health Court is available in the service area;

iv. Participation in Mental Health and Law Enforcement collaboration meetings; and

v. Communication of court ordered requirements, limitations, and court dates.

(c) Assist the Individual in accessing community supports that will promote recovery and community integration, including, but not limited to:

i. Case management;

ii. Skills training;

iii. Crisis services;

iv. Individual or group therapy;

v. Alcohol and drug addiction treatment; and

vi. Psychiatric prescription management and medication education.

(d) Administrative activities related to the Restoration Services described above, including but not limited to:

i. Reporting of the Individual's compliance with the conditional release requirements through monthly reports to appropriate court; and

ii. Providing interim quarterly reports for the purpose of communicating current status of Individuals to Oregon Health Authority/Health Systems Division (OHA/HSD) and the court of jurisdiction.

(2) The County shall allocate reasonable staffing within available funding to meet the needs of the community and provide the necessary Services as described in subsection a. above.

b. **Performance Requirements**

Providers of MHS 04 Services funded through this Agreement:

(1) Shall comply with ORS 161.365, ORS 161.370, OAR 309-088-0105, OAR 309-080-0115, OAR 309-088-0125, and OAR 309-088-0135, as such statutes and rules may be revised from time to time; and

(2) May reasonably use funds to improve outcomes and services for Individuals found unfit to proceed by improving systems and collaboration effecting this population.

c. **Reporting Requirements**

See Exhibit E, 10.

d. **Special Reporting Requirements**

County shall prepare and electronically submit, to amhcontract.administrator@dhsoha.state.or.us, written quarterly reports on the delivery of MHS 04 Services, no later than 45 calendar days following the end of each subject quarter for which financial assistance is awarded through this Agreement. Reports must be prepared using forms and procedures prescribed by OHA. Forms are located at http://www.oregon.gov/OHA/HSD/AMH/Pages/Reporting-Requirements.aspx. Each quarterly report shall provide the following information per month for each subject quarter:

(1) For Individuals who have a community consultation completed, provide the following information:

(a) Individuals' name;

(b) Gender;

(c) Date of birth

(d) Medicaid identification number (if applicable);

(e) Race;

(f) Ethnicity;

(g) Living Situation;

(h) Consultation referral date;

(i) Consultation face-to-face date;

(j) Date the findings report was provided to the court;

(k) Recommendation from the findings report provided to the court; and

(l) Court's determination on Individual's placement.

(2) For Individuals who are engaged in community-based restoration services, provide the following information:

(a) Individual's name;

(b) Gender;

(c) Date of birth

(d) Medicaid identification number (if applicable);

(e) Race;

(f) Ethnicity;

(g) Living situation;

(h) Beginning date of restoration services; and

(i) Description of services provided.

e. Financial Assistance Calculation, Disbursement, and Confirmation of Performance and Reporting Requirement Procedures

See Exhibit D, Payment, Settlement, and Confirmation Requirements.
Use Payment and Confirmation language.

17. Service Name: **ASSERTIVE COMMUNITY TREATMENT SERVICES (ACT)**
Service ID Code: **MHS 05**

a. **Service Description**

(1) **Definitions:**

(a) **Assertive Community Treatment (ACT)** means an evidence-based practice designed to provide comprehensive treatment and support Services to Individuals with Serious and Persistent Mental Illness. ACT is intended to serve Individuals who have severe functional impairments and who have not responded to traditional psychiatric outpatient treatment. ACT Services are provided by a single multi-disciplinary team, which typically includes a psychiatrist, a nurse, and at least 2 case managers, and are designed to meet the Individual's needs and to help keep the Individual in the community and out of a structured service setting, such as residential or hospital care. ACT is characterized by:

i. Low client to staff ratios;

ii. Providing Services in the community rather than in the office;

iii. Shared caseloads among team members;

iv. 24-hour staff availability;

v. Direct provision of all Services by the team (rather than referring Individuals to other agencies); and

vi. Time-unlimited Services.

(b) **ACT-Eligible Individual** means an Individual who meets ACT Admission Criteria established in OAR 309-019-0245.

(c) **Competitive Integrated Employment** means full-time or part time work, at minimum wage or higher, at a rate that is not less than the customary rate paid by the employer for the same or similar work performed by other employees who are not Individuals with disabilities, and who are similarly situated in similar occupations by the same employer and who have similar training, experience, and skill; with eligibility for the level of benefits provided to other employees; at a location where the employee interacts with other persons who are not Individuals with disabilities (not including supervisory personnel or individuals who are providing services to such employee) to the same extent that individuals who are not Individuals with disabilities and who are in comparable positions interact with other persons; and as appropriate, presents opportunities for advancement that are similar to those for other employees who are not individuals with disabilities and who have similar positions.

(d) **Division Approved Reviewer** means the Oregon Center of Excellence for Assertive Community Treatment (OCEACT). OCEACT is OHA's contracted entity responsible for conducting

ACT fidelity reviews, training, and technical assistance to support new and existing ACT Programs statewide.

(e) **Serious and Persistent Mental Illness (SPMI)** means the current Diagnostic and Statistical Manual, Fifth Edition (DSM V) of the American Psychiatric Association, incorporated by reference herein, diagnostic criteria for at least one of the following conditions, as a primary diagnosis for an Individual 18 years of age or older:

i. Schizophrenia and other psychotic disorders;

ii. Major depressive disorder;

iii. Bipolar disorder;

iv. Anxiety disorders limited to Obsessive Compulsive Disorder (OCD) and Post Traumatic Stress Disorder (PTSD);

v. Schizotypal personality disorder; or

vi. Borderline personality disorder.

(2) **Services:**

(a) ACT is an evidence-based practice for Individuals with SPMI. ACT is characterized by:

i. A team approach;

ii. Community based;

iii. A small client-to-staff caseload, typically 10:1, to consistently provide necessary staffing diversity and coverage;

iv. Time-unlimited Services;

v. Flexible Service delivery;

vi. A fixed point of responsibility; and

vii. 24/7 crisis availability.

(b) MHS 05 Services include, but are not limited to:

i. Hospital discharge planning;

ii. Case management;

iii. Symptom management;

iv. Psychiatry services;

v. Nursing services;

vi. Co-occurring substance use and mental health disorders treatment services;

vii. Supported Employment (reference OAR 309-019-0275 through 309-019-0295);

viii. Life skills training; and

ix. Peer support services.

(c) The ACT Program is intended to serve Individuals (18 year old or older) with SPMI and who meet ACT Program admission criteria as described in OAR 309-019-0245.

(d) A Provider delivering MHS 05 Services with funds provided through this Agreement may not use MHS 05 Services funding to deliver covered Services to any Individual known to be enrolled in the Oregon Health Plan.

(e) An ACT Program includes the following staff members:

i. Psychiatrist or Psychiatric Nurse Practitioner;

ii. Psychiatric Nurse(s);

iii. Qualified Mental Health Professional (QMHP) ACT Team Supervisor;

iv. Qualified Mental Health Professional(s) (QMHP) Mental Health Clinician;

v. Substance Abuse Treatment Specialist;

vi. Employment Specialist;

vii. Housing Specialist;

viii. Mental Health Case Manager; and

ix. Certified Peer Support Specialist.

b. **Performance Requirements**

County shall provide MHS 05 Services in a manner that meets minimum fidelity requirements and adheres to all standards in OAR 309-019-0225 through 309-019-0255.

If County lacks qualified Providers to deliver MHS 05 Services and supports, County shall implement a plan, in consultation with their respective CCO and OHA, to develop a qualified Provider network for Individuals to access MHS 05 Services.

The County shall work with their respective CCO to increase the number of eligible Individuals, with SPMI, served by ACT Team(s). If 10 or more Individuals in a County's region have been referred, are eligible and appropriate for MHS 05 Services, and are on a waiting list for more than 30 calendar days to receive MHS 05 Services, the County shall work with their appropriate CCO to take action to reduce the waitlist and serve those Individuals by:

(1) Increasing team capacity to a size that is still consistent with fidelity standards; or

(2) Adding additional ACT Team(s).

c. **Reporting Requirements**

See Exhibit E, 10.

d. Special Reporting Requirements

County shall prepare and electronically submit, to amhcontract.administrator@state.or.us, written quarterly summary reports on the delivery of MHS 05 Services no later than 45 calendar days following the end of each subject quarter for which financial assistance is awarded through this Agreement. Reports must be prepared using forms and procedures prescribed by OHA. Forms are located at http://www.oregon.gov/OHA/HSD/AMH/Pages/Reporting-Requirements.aspx.

Each report shall provide the following information:

(1) Individuals served;

(2) Individuals who are homeless at any point during a quarter;

(3) Individuals with safe stable housing for 6 months;

(4) Individuals using emergency departments during each quarter for a mental health reason;

(5) Individuals hospitalized in OSH or in an acute psychiatric facility during each quarter;

(6) Individuals hospitalized in an acute care psychiatric facility during each quarter;

(7) Individuals in jail at any point during each quarter;

(8) Individuals receiving Supported Employment Services during each quarter;

(9) Individuals who are employed in Competitive Integrated Employment; and

(10) Individuals receiving MHS 05 Services who are not enrolled in Medicaid Referrals and Outcomes, including the following:

(a) Number of referrals received during each quarter;

(b) Number of Individuals accepted during each quarter;

(c) Number of Individuals admitted during each quarter; and

(d) Number of Individuals denied during each quarter and the reason for each denial.

e. Financial Assistance Calculation, Disbursement, and Confirmation of Performance and Reporting Requirements Procedures

See Exhibit D, Payment, Settlement, and Confirmation Requirements.

Use Payment and Confirmation language.

18. Service Name: **CRISIS AND ACUTE TRANSITION SERVICES (CATS)**

Service ID Code: **MHS 08**

a. Service Description

MHS 08 –Crisis and Acute Transition Services (CATS) are designed to provide a community-based alternative to Emergency Department "boarding" for children, youth, and young adults (Individuals) in need of acute psychiatric treatment, who are awaiting inpatient psychiatric hospitalization.
The program includes and requires brief crisis services, stabilization, and transition to community-based supports and services when Individuals from birth through 24 years of age present to emergency departments or crisis centers and are at risk of admission for psychiatric or behavioral crises. Programs must serve all Individuals presenting in the settings indicated above, including those with public, private, or no insurance.

b. Performance Requirements

(1) Eligible Population: Individuals from birth through 24 years of age who have symptoms consistent with psychiatric or serious emotional disorders, and present at program partner Emergency Departments or community crisis centers (those that have a contractual agreement with the OHA Contract holder or County). This includes Individuals who are uninsured, underinsured, not eligible for Medicaid, or have exhausted Medicaid services, including those who meet the criteria for the Citizen Alien Waived Medical Program. Programs are expected to maximize this funding to enhance an existing continuum of crisis and acute care for Individuals and families through the provision of the elements listed below.

(2) Clinical, Social, and Residential Services Provided:

(a) These Services are appropriate when the Individual is given a mental health and safety assessment, has reached an established level of acuity (through administration of a standardized acuity measure), and it is deemed safe, appropriate, and optimal to refer them to a CATS program.

(b) Clinical Services normally last up to 45 calendar days, or as long as is necessary to provide the Individual and their family with sufficient stabilization and support to establish strong connectivity with community-based supports.

(c) Initial contact from the clinical team will occur within 1-3 hours of the referral. Within 72 hours of the referral, both the family partner and the clinical team will meet with the Individual and family together. Contacts should be as frequent as is necessary for the goals of the project to occur, in person as much as possible, but no less than twice per week.

(3) CATS programs are team-based. Each team provides an array of recovery-oriented agency or community-based services and supports, including, but not limited to:

(a) Functioning as a collaborative unit, sharing duties, information and support for each Individual and family. This requires ongoing and frequent communication, supportive interagency processes, and intentional organization to support the provision of CATS as a model of coordinated care. The work is organized and agreed upon through a Memo of Understanding (MOU) between each program's partners, to be submitted to OHA within 45 calendar days of the execution of the contract. Hospitals must be partners in the service design and delivery;

(b) Conducting assessment, that includes mental health assessment, safety assessment, acuity level and safety plan prior to discharge from crisis center or emergency department;

(c) Alleviating the immediate crisis through connections to the family and Individual, and work with mental health team members;

(d) Providing CATS Guidebook for Families, or the equivalent, describing to the Individual and family the anticipated experience in the CATS program, and providing Individuals and families with relevant and individualized psycho-social information. An equivalent resource means a guide or booklet (print or online) which includes all items listed in the Family Transition Inventory/Checklist, and which has been reviewed and approved by OHA and OHSU staff. OHA staff will contact Contractor via email to notify Contractor of approval;

(e) Establishing with the family and Individual a transition plan designed to safely prevent readmission to the emergency department, and improved access and connectivity to community resources;

(f) Conducting a closing meeting (in-person or via phone) must be completed with the family prior to transitioning care, and data must be collected at this meeting. If the team is unable to have a closing meeting with the family, documentation explaining the circumstances is required;

(g) Participation in collaborative state-wide efforts to establish shared programmatic standards, expectations for results and services, and key reporting requirements; and

(h) Specific services associated with the required elements must include, but are not limited to:

i. Suicide-Related Interventions: Safety assessment, Counseling On Lethal Means (CALM), and lethal means counseling where needed;

ii. Family and Young Adult Peer Support;

iii. Access to and coordination of immediate resources:

iv. Brief mental health therapy provided during CATS participation;

v. Rapid access to psychiatric and counseling services;

vi. Transition to existing health and community resources; and

vii. Use of linguistically and culturally appropriate materials for the Individual and family, necessary for them to understand and to participate fully in the CATS program.

(4) Who Can Provide These Services:

(a) Family and youth peer support specialists, care coordinators, licensed medical prescribers, Qualified Mental Health Professional (QMHP), mental health therapists, and skills trainers;

(b) Programs must provide dedicated CATS staff and family partners. Those individuals are presented to the Individual and family as a combined resource that is the cornerstone of the CATS model;

(c) Recommended supplemental training might include supplemental peer and clinical training in crisis response, use of the CATS Guidebook for Families, use of the Oregon Health Sciences University (OHSU) RedCap survey, and any others that would enhance work with families in crisis; and

(d) Staff working in the programs must have training in suicide prevention and intervention strategies, and Trauma Informed Care (TIO), and must be provided with ongoing maintenance of the skills and practice associated with these approaches.

(5) Setting(s) for service delivery: Emergency departments, crisis centers, provider sites, homes, and community settings. Locations as preferred by the Individual and family, and family-inclusive safety planning.

(6) County is required to monitor sub-contracted Services and provide initial copies of the sub-contract to OHA staff, and work with OHA staff to devise an ongoing monitoring process.

c. **Reporting Requirements**

See Exhibit E, 10.

d. **Special Reporting Requirements**

County or sites providing MHS 08 Services directly to Individuals shall submit data quarterly, as specified by OHA, directly to the Oregon Health & Science University (OHSU) RedCap Data System.
Programs are expected to meet data reporting requirements to input data within 14 calendar days of closure, unless otherwise arranged with the OHSU/OHA team. This includes timely collection and submission of outcome-based measures for each Individual in the program, including but not limited to, demographic and presenting referral information, KIDSCREEN-10, Crisis Assessment Tool, intervention details, and transition plan details.

(1) Survey data that includes, but is not limited to, the following:

(a) Client demographics;

(b) Presenting diagnosis and issues;

(c) Diversions;

(d) Re-admissions;

(e) Response time;

(f) Connectivity with peer support;

(g) Initial contacts;

(h) Frequency of contact;

(i) Transitional service referrals; and

(j) Other information deemed beneficial to the development of the Service.

(2) Programs are required to encourage and enable CATS program participants, both Individuals and family members, to participate in a follow-up study. Staff from OHSU Child and Adolescent Psychiatry Unit will follow-up with CATS participants at exit and at established post exit interviews. Data from follow-up interviews will be shared with program teams and agencies with the goal of improved services.

(3) Programs will submit annual budget reports to OHA, detailing funds spent on specific services, staffing, administrative costs, and other costs associated with the program. In addition, programs will be asked to describe the other types of funding and insurance payments used to conduct program services.

e. **Financial Assistance Calculation, Disbursement, and Confirmation of Performance and Reporting Requirement Procedures**

See Exhibit D, Payment, Settlement, and Confirmation Requirements.
Use Payment and Confirmation language.

19. **Service Name:** **JAIL DIVERSION SERVICES**
Service ID Code: **MHS 09**

a. **For purposes of this Service Description, the following definitions apply:**

(1) **Jail Diversion Services,** as defined by the Oregon Performance Plan, means community-based Services that are designed to keep Individuals with behavioral health issues out of the criminal justice system and, instead, supported by other community-based services, such as mental health services, substance abuse services, employment services, and housing. Jail Diversion Services are intended to minimize contact with law enforcement, avoid jail time, and/or reduce jail time. These Services are intended to result in the reduction of the number of Individuals with mental illness in the criminal justice system or the Oregon State Hospital.

(2) **SPMI** means the current Diagnostic and Statistical Manual, Fifth Edition (DSM V) of the American Psychiatric Association, incorporated by reference herein, diagnostic criteria for at least one of the following conditions, as a primary diagnosis for an adult 18 years of age or older:

(a) Schizophrenia and other psychotic disorders;

(b) Major Depressive Disorder;

(c) Bipolar Disorder;

(d) Anxiety disorders limited to Obsessive-Compulsive Disorder (OCD) and Post-Traumatic Stress Disorder (PTSD);

(e) Schizotypal Personality Disorder; or

(f) Borderline Personality Disorder.

b. **Service Description**

MHS 09 Jail Diversion Services increase Mental Health's interaction with Individuals with Serious and Persistent Mental Illness (SPMI) who are involved with justice or law enforcement solely due to a mental health reason and are charged with low-level crimes, resulting in the reduction or avoidance of arrests, jail admissions, lengths of stay in jail, and recidivism through the availability of alternative community-based services, programs, or treatments.

c. **Performance Requirements**

All Providers shall adopt the "**Sequential Intercept Model**" (SIM), and incorporated by reference herein, through the GAINS Center to more effectively deal with mentally ill Individuals who come into contact with law enforcement personnel. All Providers shall use the SIM to identify and intervene upon "points of interception" or opportunities for interventions to prevent Individuals with SPMI from entering or penetrating deeper into the criminal justice system.

County shall provide the following, subject to the not-to-exceed amount of this Agreement, pre-booking and post-booking MHS 09 Services:

(1) Create partnerships or diversion agreements between law enforcement agencies, jails, both circuit and municipal courts, and local mental health providers;

(2) Create opportunities for Individuals to access housing in addition to vocational and educational services;

(3) Provide support services to prevent or curtail relapses and other crises;

(4) Assist Individuals to negotiate and minimize continuing criminal sanctions as they make progress in recovery and meet criminal justice obligations; and

(5) Promote peer support and the social inclusion of Individuals with or in recovery from mental and substance use disorders in the community.

d. Reporting Requirements

See Exhibit E, 10.

e. Special Reporting Requirements

County shall prepare and electronically submit through secure e-mail as described in the Security and Privacy Agreement, to amhcontract.administrator@state.or.us, written quarterly reports on the delivery of MHS 09 Services no later than 45 calendar days from the end of each subject quarter for which financial assistance is awarded through this Agreement. Reports must be prepared using forms and procedures prescribed by OHA. Forms are located at http://www.oregon.gov/OHA/HSD/AMH/Pages/Reporting-Requirements.aspx.

Each quarterly report shall include, but is not limited to, the following:

(1) For Individuals receiving MHS 09 Services, report the following:

(a) Individuals name;

(b) Gender;

(c) Date of birth;

(d) Medicaid identification number (if applicable);

(e) Race;

(f) Ethnicity;

(g) Whether the Individual has an SPMI diagnosis;

(h) Identify whether the Individual received pre or post booking Services;

(i) Number of times Individual was arrested during the reporting period;

(j) Charges Individual was arrested for during the reporting period; and

(k) Description of Service provided.

(2) Report the number of incidences where charges were dismissed or dropped as a result of MHS 09 Services.

(3) Report the number of crisis consultations provided by mental health staff in pre-booking diversions.

(4) Provide a detailed description of any MHS 09 Service created prior to the current reporting period.

(5) Provide information regarding any activities related to MHS 09 Services that involved law enforcement agencies, jails, circuit and municipal courts, community corrections, and local mental health providers.

f. **Financial Assistance Calculation, Disbursement, and Confirmation of Performance and Reporting Requirement Procedures**

See Exhibit D, Payment, Settlement, and Confirmation Requirements.

Use Payment and Confirmation language.

20. Service Name: **MENTAL HEALTH PROMOTION AND PREVENTION SERVICES**

Service ID Code: **MHS 10**

a. Service Description

MHS 10 Mental Health Promotion and Prevention Services are directed at changing common influences on the development of Individuals across their lifespan, reducing risk factors, and increasing protective factors, and is designed to target universal, selected, and indicated populations based on risk.

MHS 10 Services are interventions that aim to enhance an Individual's abilities to achieve developmentally appropriate tasks (competence), a positive sense of self-esteem, mastery, well-being, social inclusion, and strengthen their ability to cope with adversity.

Services shall be trauma informed and support the expansion of Mental Health Promotion and Prevention by strengthening the determinants of mental health and wellness, including the development of health communities, individual skill development, improved social emotional competence, and decreasing risk factors associated with negative mental health outcomes, such as adverse childhood experiences.

b. Performance Requirements

County shall prepare and submit to OHA for approval within 30 calendar days of the effective date of this Agreement, a written plan outlining how services as listed below will be provided using funds received through this Agreement.

(1) County shall:

(a) Strengthen the existing Mental Health Promotion and Prevention Services infrastructure, or build and develop new infrastructure.

(b) Support the Institute of Medicine Mental Health Promotion Classifications in the Continuum of Care Model.

i. Development and maintenance of healthy communities: Conduct interventions that may include, but are not limited to community safety promotion, violence reduction, bullying prevention, community connectively, and resource dissemination activities;

ii. Skill development: Interventions that include, but are not limited to programs based in schools, community centers, and other community-based settings that promote social and emotional competence through activities that emphasize social connection, problem solving and development of self-regulation; and

iii. Social emotional competence: Interventions may include, but are not limited to developing or sustaining community infrastructure, parenting education, stress reduction classes, communication skills classes, grief and other post distress supports, divorce and other losses, and community-based activities of which promote inclusion.

(c) Promote activities that demonstrate a working relationship with a Coordinated Care Organization (CCO), and community-based organizations, such as:

i. A commitment to work with the community-based organization to increase efficiency and broaden coordination of initiatives within, and crossing between, the community and health care settings to improve prevention and mental health promotion activities;

ii. A commitment to work with the community-based organization to continue the development of sustainable systems to address primary prevention and mental health promotion activities in the community and health system settings;

iii. A commitment to responsibility with experience engaging and providing mental health promotion services to communities of color, and in other underserved populations in a culturally and linguistically-appropriate manner; or

iv. Propose and implement joint strategies to sustain project work beyond the funding period, including the ability to engage other community organizations or stakeholders who will benefit from a healthier overall population, such as other public or commercial insurance carriers.

c. Special Reporting Requirements

County shall prepare and electronically submit, to amhcontract.administrator@state.or.us, written semi-annual (two times per year) detailed budget expenditure and service reports on the delivery of Mental Health Promotion and Prevention Services, no later than 45 calendar days following the end of each subject term for which financial assistance is awarded through this Agreement. Reports must be prepared using forms and procedures prescribed by OHA. Forms are located at http://www.oregon.gov/OHA/HSD/AMH/Pages/Reporting-Requirements.aspx.

Each report shall contain the following information:

(1) An explanation of activities conducted during the reporting period, and how each activity is supported in the following interventions:
- **(a)** Development and maintenance;
- **(b)** Skill development; and
- **(c)** Social emotional competence.

(b) A description of how activities impacted Mental Health Promotion and Prevention Services.

d. Financial Assistance Calculation, Disbursement, and Confirmation of Performance and Reporting Requirement Procedures

See Exhibit D, Payment, Settlement, and Confirmation Requirements.
Use Payment and Confirmation Requirements language.

21. **Service Name:** **RENTAL ASSISTANCE PROGRAM SERVICES**

Service ID Code: **MHS 12**

a. **Service Description**

MHS 12 Rental Assistance Program Services are intended to assist Individuals 18 years of age and older with Serious and Persistent Mental Illness (SPMI), as defined in OAR 309-036-0105 (13), and who meet one of the criteria listed below, in paying for rental housing to live as independently as possible in the community and to access the appropriate support services on a voluntary basis.

(1) SPMI means the current Diagnostic and Statistical Manual, Fifth Edition (DSM V) of the American Psychiatric Association, incorporated by reference herein, diagnostic criteria for at least one of the following conditions, as a primary diagnosis for an adult 18 years of age or older:

(a) Schizophrenia and other psychotic disorders;

(b) Major Depressive Disorder;

(c) Bipolar Disorder;

(d) Anxiety disorders limited to Obsessive-Compulsive Disorder (OCD) and Post-Traumatic Stress Disorder (PTSD);

(e) Schizotypal Personality Disorder; or

(f) Borderline Personality Disorder

(2) Criteria in paying for rental housing requires at least one of the following conditions:

(a) Transitioning from the Oregon State Hospital;

(b) Transitioning from a licensed residential setting;

(c) Without supported housing, are at risk of reentering a licensed residential or hospital setting. For purposes of this special project, supported housing is a combination of financial assistance and supportive services that allows an Individual to live as independently as possible in their own home;

(d) Homeless as defined in 42 U.S.C. § 11302; or

(e) At risk of being homeless.

b. **Performance Requirements**

(1) MHS 12 Services includes financial assistance for a residential specialist position and a peer support specialist position. For purposes of this special project, the residential and peer support specialist positions shall be responsible for coordinating the program components such as application process, finding a rental unit, and payments to the landlord; and the support service components including, but not limited to, financial budgeting, applying for mainstream housing resources (like Section 8), community navigation, and maintaining healthy relationships, which supports Individuals in their ability to live as independently as possible in the community. These allotments shall not be used to pay any other staff

position, and these two MHS 12 funded positions will only perform work for this MHS 12 program.

(2) MHS 12 Services financial assistance per Individual will be set by OHA and will not exceed the HUD Fair Market Rent (FMR). Financial assistance for rental assistance made on behalf of Individuals covers payment to landlords, property management companies, housing providers, property owners, or specific vendors for a portion of the monthly rent, or payment to specific vendors for resident utility expenses.

(3) Move-in expense and barrier removal financial assistance will be based on the Individual's need and determined by the Program based on their program design as described in their application. Financial assistance for move-in and barrier removal costs may include cleaning and security deposits, pet deposits, outstanding utility bills, and other related costs as determined in the County's program design.

(4) Rental housing units subject to this special project shall have an inspection, and pass the inspection prior to move-in, which shall be conducted by County or its contractor, based upon the criteria outlined in the OHA approved Housing Condition Checklist located at http://www.oregon.gov/oha/HSD/AMH/Pages/Reporting-Requirements.aspx.

(5) County shall coordinate with Coordinated Care Organizations (CCO) and Community Mental Health Programs (CMHP) to develop a plan to bill for Medicaid eligible services.

(6) Administrative costs shall not exceed 15% of total operating budget. Eligible administrative costs include:

(a) Financial assistance for MHS 12 Services data collection and documentation of Service delivery in compliance with state and federal requirements; and

(b) Financial assistance for housing inspection services, accounting services, computer upgrades, supervision of program staff, expenses associated with program staff, office space, and other appropriate office expenses.

(7) Utilization requirements for MHS 12 Services Providers will be identified in a special condition in a particular line of Exhibit C, "Financial Assistance Award."

(8) County Compliance: No more than 25% of units in a building or complex of buildings is encouraged for Individuals with SPMI referred by the state, its contractors, or its subcontractors. County or subcontractor shall make good faith, reasonable best efforts to facilitate the use of those units by persons with SPMI. The remaining housing is available to all tenants, in conformance with Fair Housing and other related laws.

(9) Compliance with criteria in the County's application, award letter, and this Agreement is equally binding.

(10) County may only contract with subcontractors, subject to prior review and approval by OHA.

c. Special Reporting Requirements

(1) County shall prepare and electronically submit, to amhcontract.administrator@state.or.us, written quarterly reports on the delivery of MHS 12 Services no later than 45 calendar days following the end of each subject quarter for which financial assistance is awarded through this Agreement. Reports must be prepared using forms and procedures prescribed by OHA. Forms are located at http://www.oregon.gov/OHA/HSD/AMH/Pages/Reporting-Requirements.aspx.

(2) For financial use, each report shall provide the following information for the subject quarter totals:

(a) Amount expended for move-in and barrier removal services;

(b) Amount expended for housing rental;

(c) Amount expended for staff positions and administration; and

(d) The number of housing slots rent was paid for MHS 12 Individuals.

d. Financial Assistance Calculation, Disbursement, and Agreement Settlement Procedures

See Exhibit D, Payment, Settlement, and Confirmation Requirements.

Use Payment and Settlement language. In addition:

(1) Amounts due for Services based on the cash assistance paid on behalf of the program providers for rental assistance, barrier removal, move-in expenses, program staff funds expended, and administration of this special project as properly reported in accordance with the "Special Reporting Requirements" section above and subject to the utilization requirements in a special condition on that line of the Financial Assistance Award, is subject to the terms and limitations in this MHS 12 Service Description.

(2) For Services to non-Medicaid-eligible Individuals, County shall submit a combined quarterly invoice, itemized as follows:

(a) Number of housing slots filled per month.

(b) For quarters 1 and 2, County shall request the total amount for all MHS 12 slots as specified in that line of the Financial Assistance Award;

(c) For quarter 3 through 8, County shall request the total MHS 122 amount paid based on the Fair Market Rate (FMR) specified in that line of the Financial Assistance Award, times the total number of units of rent paid on behalf of MHS 12 Individuals during the subject quarter.

(3) The Part C financial assistance will be disbursed as follows:

Unless a different disbursement method is specified in that line of Exhibit C, "Financial Assistance Award," OHA will disburse the Part C funds for MHS 12 Services provided under a particular line of the Financial Assistance Award containing a "C" in column "Part ABC" to County per receipt and approval of a quarterly written invoice with required

attachments, as specified below, in the allotment during the period specified in that line of the Financial Assistance Award. Invoice and required attachments are due no later than 45 calendar days following the end of the subject quarter and must be submitted to amhcontract.administrator@state.or.us with the subject line "Invoice, contract #(your contract number), contractor name." Financial assistance provided by OHA are subject to the limitations described in this MHS 12 Service Description.

For Services to non-Medicaid-eligible Individuals, County shall submit a combined quarterly invoice, itemized as follows:

(a) Number of housing slots filled per month;

(b) For quarters 1 and 2, County shall request the total amount for all MHS 12 slots as specified in that line of the Financial Assistance Award.

(c) For quarter 3 through 8, County shall request the total MHS 12 amount paid based on the Fair Market Rate (FMR) specified in that line of the Financial Assistance Award, times the total number of units of rent paid on behalf of MHS 12 Individuals during the subject quarter.

22. **Service Name:** **SCHOOL BASED MENTAL HEALTH SERVICES**

Service ID Code: **MHS 13**

a. **Service Description**

County shall provide MHS 13 School-Based Mental Health Services to identified K-12 schools, that are not affiliated with a School-Based Health Center providing mental health services. County shall confirm that an appropriately qualified school based mental health service provider is available at identified schools. Counties shall provide appropriate levels of clinical supervision as set forth in OAR 309-019-0130 for school based mental health service providers. School Based Mental Health Services providers includes a state licensed or state Qualified Mental Health Professional (QMHP), licensed under state law to provide mental health services to children and adolescents.

School based mental health services are essential components of comprehensive learning supports. Access to school-based mental health services is linked to students' improved physical and psychological safety and reduces costly negative outcomes such as risky behaviors, disciplinary incidents, delinquency, dropout, substance abuse, and involvement with the criminal justice system. The provision of school based mental health services at the school, during the school day, will reduce the likelihood that students will need to miss school, drop out of school or have other undesirable outcomes that result in a missed opportunity to remain in school, retain satisfactory academic progress, and have quality of life.

b. **Performance Requirements**

(1) The primary role of MHS 13 Services providers is to provide school-based direct clinical services, care coordination when indicated, and support, or provide training to school personnel as follows:

(a) Provide school-based clinical services for rapid and easily accessible mental health treatment, and facilitate services needed for outpatient mental health and substance use treatment. Crisis services shall be prioritized.

(b) Provide trauma informed and coordinated care to improve school safety, provide crisis intervention, and mental health services to Individuals referred or self-referred, due to behavioral and emotional challenges, symptoms of mental illness, truancy, or behavioral issues in the classroom.

(c) Provider shall meet with the Individual and/or family, as clinically indicated, to complete a behavioral health risk assessment and facilitate access to appropriate mental health services, medical services, and other needed resources in the community.

(d) Collaboration with families whenever possible promotes treatment integrity and success at home and in school. When clinically indicated, collaboration with the family including family therapy, if warranted, shall occur.

(e) Assist with the development of programs such as Wellness, peer support programs, family support programs, Mental Health First Aid

training, and implementation of social emotional learning in the classroom. Provide consultation to school personnel on topics related to behavioral health issues that support students, through information learning opportunities. Promote discussions on topics such as conflict resolution, anxiety, depression, managing suicidal feeling, self-regulation, healthy relationships, and other topics.

(2) Through collaboration with the school, assist and create activities to improve climate and safety for children. Assist schools with data on bullying and harassment needed for state report cards. Create mechanisms for individuals to report plans by other children, adolescents, or adults to commit violence, and report incidents of any violence, so timely intervention may occur, and promote school safety for all students.

(3) MHS 13 Services providers shall be trained in suicide prevention, intervention and postvention. Documentation of training in Lethal Means and Safety Planning for each provider shall be submitted to OHA. MH 13 Services providers are obligated to report any known suicides in the school to their supervisor. Supervisors shall notify county staff who will report to the OHA Suicide Prevention and Intervention coordinator in accordance with OAR 309-027-0060.

(4) If County lacks qualified Providers to deliver MHS 13 Services, County shall notify OHA in writing prior to, or as soon as services become unavailable, and implement a plan for the provision of Services in consultation with OHA.

(5) If County would like to provide Services to other schools in addition to the identified high-risk schools, County shall notify OHA in writing. Elementary schools shall be prioritized in this process.

(6) If schools identified as having Individuals with a high unmet mental health need decline Services, OHA reserves the right to reduce funding based on inability of the County to deliver MHS 13 Services to identified schools.

(7) MHS 13 provides funding for mental health clinicians to be located in the school for the purpose of mental health outreach, engagement, and consultation with school personnel. Medicaid billable Services must be billed to Medicaid. Funding may also be used to serve Individuals experiencing acute psychiatric distress and who are not Medicaid eligible and who have no other resources to pay for the Services.

c. Reporting Requirements

See Exhibit E, 10.

d. Special Reporting Requirements

County shall prepare and electronically submit, to amhcontract.administrator@state.or.us, written quarterly reports on the delivery of MHS 13 Services, no later than 45 calendar days following the end of each subject quarter for which financial assistance is awarded through this Agreement. Reports must be prepared using forms and procedures prescribed by OHA. Forms are located at http://www.oregon.gov/OHA/HSD/AMH/Pages/Reporting-Requirements.aspx.

Each report shall provide the following information:

(1) The names and National Provider Index numbers of each Provider designated to provide the MHS 13 Services, or of the supervisor if the therapist does not have an NPI number;

(2) A summary of the number of Individuals served, their Oregon Health Plan ID number, the full name of the school the student attends, the name of the therapist serving the Individual, and the number of times during that quarter the Individual and therapist met;

(3) A summary of accomplishments with specific examples, and barriers to the implementation of MHS 13 Services shall also be provided in the report. Counties shall include in their quarterly report how the existing program addresses adverse childhood experiences, the critical mental and behavioral health challenges facing youth, and how this work promotes school and student safety;

(4) Measure outcomes of therapy using an outcome-based tool. Make this information available to the OHA contract administrator is requested.

(5) Service providers mush report evidence of use of a universal research informed suicide assessment tool.

e. Financial Assistance Calculation, Disbursement, and Confirmation of Performance and Reporting Requirement Procedures

See Exhibit D, Payment, Settlement, and Confirmation Requirements.

Use Payment and Confirmation language.

23. **Service Name:** **YOUNG ADULT HUB PROGRAMS (YAHP)**

Service ID Code: **MHS 15**

a. **Service Description**

MHS 15 Services are designed to reach out to, engage, and support extremely distressed and marginalized young adults (Individuals) 14 through 24 years of age with Mental Health conditions, particularly those that are disconnected from services or who have no other resources to pay for services.

(1) The program includes and requires outreach and engagement, brief crisis services, connection of the Individual with community-based supports and services, peer support, clinical and other health related services;

(2) Programs must serve all Individuals referred to the service, including those with public, private or no insurance; and

(3) Programs must deliver services in a manner supported by the principles of systems of care, trauma informed care, and positive youth development.

b. **Performance Requirements**

(1) **Eligible Population**:

These Services are considered appropriate when the Individual is not connecting with desired behavioral health and other supports through other, more traditional or generally available means, and needs supplemental or alternative engagement supports. This may include, but are not limited to Individuals 14 through 24 years of age who have been:

(a) Served in Psychiatric Residential Treatment Services, Secure Adolescent Inpatient Programs;

(b) Chronically involved in state systems of Mental Health care and who are in need of intensive community supports;

(c) Impacted by a Mental Health diagnosis and/or extreme social distress so that their ability to be successful in age appropriate activities is impaired or has led to interface with the criminal justice system; or

(d) Disconnected from resources to such an extent that they are unlikely to access Medicaid and privately insured services through an outpatient program.

(2) **Provide Clinical, Social, and Residential Services**:

These services have no time limit. It is expected that they will be used to help the Individual connect to ongoing, longer-term supports, meet their needs and goals, and support them in moving toward a positive life trajectory. It is preferable that the peer support specialist and the clinical staff meet with the Individual together during the initial contact or soon thereafter. Contacts should be as frequent as is necessary for the goals of the project to occur, but no less than twice a week. Provider shall assist the Individual in accessing and maintaining resources that fit his or her goals. Such resources may include supported employment, housing, educational support, primary care, psychiatric services, addictions services, navigation

of outside supports and services, family mentoring and mediation, and family finding through the use of a family finding service, among others. Setting(s) for service delivery include, but are not limited to emergency departments, crisis centers, provider sites, homes, and community settings. Locations shall be as preferred by the Individual. Using technology and texting as a preferred method of communication with young people is expected and required. Community-based services and supports include, but are not limited to:

(a) Outreach and engagement of very high need, high risk Individuals: lesbian, gay, bisexual or transgender (LGBT) youth, young adults with high suicide risk, and other extremely marginalized young people;

(b) Recovery oriented, young adult centered planning;

(c) Creation of social support systems;

(d) Rapid access to psychiatric and counseling services;

(e) Coaching on rights regarding access to employment, school, housing, and additional resources;

(f) Access to local teams, including licensed medical professionals (psychiatrists or psychiatric nurse practitioners), clinical case managers, supported employment specialists, and occupational therapists;

(g) Peer support provided by young adult peers, participatory decision-making;

(h) Meaningful Individual's engagement in program, community, and leadership activities; and

(i) Skill development.

(3) Who Can Provide These Services?

Recommended staff, staff expertise, and training:

(a) Providers can be youth or young adult peer support specialists, care coordinators, licensed medical prescribers, Qualified Mental Health Programs (QMHP), mental health therapists, and skills trainers.

(b) Recommended supplemental trainings includes supplemental peer and clinical training, training in suicide prevention and intervention strategies, and trauma informed care, and be provided with ongoing maintenance of the skills and practice associated with these approaches.

(c) Familiarity and use of system of care principles, trauma informed care, and the TIP Model located at http://www.tipstars.org/, or any other young adults in transition evidence-based or promising practices.

c. Reporting Requirements

See Exhibit, 10.

d. Special Reporting Requirements

County shall prepare and electronically submit, to amhcontract.administrator@state.or.us, written quarterly reports no later than 45 calendar days following the end of each subject quarter for which financial assistance is awarded through this Agreement. Reports must be prepared using forms and procedures prescribed by OHA. Forms are located at http://www.oregon.gov/OHA/HSD/AMH/Pages/Reporting-Requirements.aspx. County shall:

(1) Meet data reporting requirements and deadlines, unless otherwise arranged with OHA;

(2) Administer the Adult Hope Scale located at https://ppc.sas.upenn.edu/sites/ppc.sas.upenn.edu/files/hopescale.pdf as an outcome measurement tool, or provide an alternative measure of a consistent nature to be approved by OHA.

e. Financial Assistance Calculation, Disbursement, and Confirmation of Performance and Reporting Requirement Procedures

See Exhibit D, Payment, Settlement, and Confirmation Requirements.

Use Payment and Confirmation language.

24. Service Name: **PEER DELIVERED SERVICES (PDS)**
Service ID Code: **MHS 16**

a. Service Description

Peer Delivered Services (MHS 16will assist the establishment or expansion of Peer Delivered Services (PDS) in a specified geographic area for the period of this Agreement. PDS means an array of County or community-based services and supports provided by peers, Peer Wellness Specialists (PWS), and Peer Support Specialists (PSS), including Family Support Specialists and Youth Support Specialists, to Individuals or family members with similar lived experience and that are designed to support the needs of Individuals and families as applicable.

Peer Support Specialists are experientially credentialed individuals who have successfully engaged in their own or their child's recovery and demonstrate the core competencies for Peer Support Specialists as defined by OHA's administrative rules, Traditional Health Worker Commission, and the Office of Equity and Inclusion, ORS 414.635 through 414.665, OAR 410-180, and OAR 309-019-0130 PSS and PWS shall deliver PDS, under the supervision of a qualified Clinical Supervisor, and are listed on the Traditional Worker Registry to provide services for that identified consumer population, as found at https://traditionalhealthworkerregistry.oregon.gov.

b. Performance Requirements

County shall use the funds awarded through this Agreement for MHS 16 to implement PDS in a manner that:

(1) Benefits Individuals with mental health conditions;

(2) Increases the number of Individuals certified to provide PDS;

(3) Requires that PDS work assignments are relevant to individuals Traditional Health Worker's certification;

(4) Program staff providing direct services shall receive clinical supervision by a qualified clinical supervisor related to the development, implementation, and outcome of services;

(5) Supervision shall be provided to assist program staff to increase their skills within their scope of practice, improve quality of services to Individuals, and supervise program staff and volunteers' compliance with program policies and procedures; and

(6) For persons providing direct PDS, one of the two hours of required supervision shall be provided by a qualified Peer Delivered Services Supervisor as resources are made available.

c. **Special Reporting Requirements**

County shall prepare and electronically submit, to amhcontract.administrator@state.or.us, written quarterly reports no later than 45 calendar days following the end of each subject quarter during the period for which financial assistance is awarded through this Agreement. Reports must be prepared using forms and procedures prescribed by OHA. Forms are located at http://www.oregon.gov/OHA/HSD/AMH/Pages/Reporting-Requirements.aspx. and include the following information:

(1) Amount of funds spent as of the end of the reporting period;

(2) Description of PDS implementation progress, technical assistance needs, and any relevant implementation challenges;

(3) Number of Individuals with mental health conditions who were trained as PSS or PWS during the reporting period;

(4) Number of Individuals with mental health conditions who received PDS during the reporting period; and

(5) Outcome measures to include:

(a) Shortened psychiatric and addiction related hospital stays or reduced admissions to the emergency department due to psychiatric crisis;

(b) Improved ability to work towards recovery or establish a recovery plan;

(c) Reduced crisis events;

(d) Improved quality of life as identified by the Individuals receiving Services;

(e) Increased ability to advocate for themselves or, in the case of youth, increased ability for youth and their families to advocate for themselves and their family;

(f) Increase in a social support system;

(g) Work and education status maintenance or improvement for adults;

(h) School attendance and academic improvement for youth; and

(i) Number of out-of-home placements in the past 90 calendar days.

d. **Financial Assistance Calculation, Disbursement, and Confirmation of Performance and Reporting Requirements Procedures**

See Exhibit D, Payment, Settlement, and Confirmation Requirements.

Use Payment and Confirmation language.

25. Service Name: **NON-RESIDENTIAL MENTAL HEALTH SERVICES FOR CHILD, YOUTH, AND ADULTS**

Service ID Code: **MHS 20**

a. Service Description

(1) Definitions:

DSM 5 means The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), incorporated by reference herein, and is the 2013 update to the American Psychiatric Association's (APA) classification and diagnostic tool. The DSM serves as a universal authority for psychiatric diagnosis.

Intensive Outpatient Services means a specialized set of comprehensive in-home and community-based supports and mental health treatment services for children that are delivered in the most integrated setting in the community.

Intensive Treatment Services (ITS) means the range of services in the system of care comprised of Psychiatric Residential Treatment Facilities (PRTF) and Psychiatric Day Treatment Services (PDTS), or other services as determined by OHA, that provide active psychiatric treatment for children with severe emotional disorders and their families as defined in OAR 309-022-0105.

Child and Youth Needs and Strengths tool means a multi-purpose tool developed for children's services to support decision making, including level of care and service planning, facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. http://praedfoundation.org/tools/the-child-and-adolescent-needs-and-strenths-cans/

(2) Child and Youth Mental Health Services are:

i. Mental health services delivered to Individuals through age 17 (or through age 20 if Medicaid-eligible) who have primary mental, emotional, or behavioral health conditions diagnosed according to the DSM 5 criteria;

ii. Screening and assessment to identify appropriate mental health services for these Individuals;

iii. Referral and care coordination services with respect to mental health services delivered to these Individuals;

iv. Prioritized for Individuals who are at immediate risk of psychiatric hospitalization or removal from the home due to a mental, emotional, or behavioral health disorder or pose a danger to the health and safety of themselves of others; and

v. Services that may be delivered, as appropriate, in a clinic, home, school, or other settings familiar and comfortable for the Individual receiving such services.

(3) MHS 20 Services are:

(a) Services delivered to Individuals diagnosed with serious mental illness or other mental or emotional disturbance posing a danger to the health and safety of themselves or others.

(b) Community based services that shall include one or more of the following:

i. Use of standardized protocols and tools to identify the level of service need and intensity of care and coordination, addressing salient characteristics such as age, culture, and language;

ii. Apply OHA approved, standardized level of care tools for Individuals diagnosed with serious and persistent mental illness at intervals prescribed by OHA;

iii. Condition management and whole person approach to single or multiple conditions based on goals and needs identified by the Individual;

iv. General outpatient services including, but not limited to, care coordination and case management;

v. Medication and medication monitoring;

vi. Meaningful Individual and family involvement;

vii. Rehabilitation services including Individual, family and group counseling;

viii. Coordinate and facilitate access to appropriate housing services and community supports in the Individual's community of choice, including rent subsidy; and

ix. Other services and supports as needed for Individuals at the sole discretion of OHA.

(c) Services County shall provide, but is not limited to:

i. Outreach: Partner with healthcare providers and other social service partners who provide screening for the presence of behavioral health conditions to facilitate access to appropriate services;

ii. Early Identification and Screening: Conduct periodic and systematic methods that identify Individuals with behavioral health conditions and potential physical health consequences of behavioral health conditions which consider epidemiological and community factors, as identified in the most recently submitted and approved Local Plan; and

iii. Initiation and Engagement: Promote initiation and engagement of Individuals receiving services and supports, which may include but are not limited to:

A. Brief motivational counseling; and

B. Supportive services to facilitate participation in ongoing treatment.

b. **Performance Requirements**

Child and Youth Services:

(a) County shall comply with applicable law including, but not limited to, OAR 309-032-0301 through 309-032-0890, as such rules may be revised from time to time, and maintain a Certificate of Approval in accordance with OAR 309-039-0520 through 309-039-0540, as such rules may be revised from time to time.

(b) County is responsible for the identification of children and adolescents who would benefit from an array of intensive services determined by the child and family team by utilizing the Child and Youth Needs and Strengths tool to assess Child and Youth needs and strengths in consideration of the following risk factors?

i. Exceeding usual and customary services in a standard outpatient setting:

ii. Multiple agency involvement;

iii. Significant risk of out-of-home placement;

iv. History of one or more out-of-home placements;

v. Frequent or imminent admission to acute inpatient psychiatric hospitalization or other intensive treatment services;

vi. Significant caregiver stress;

vii. School or child care disruption due to mental health symptomology;

viii. Elevating or significant risk of harm to self or others; and

A. History of abuse or neglect;

B. Conditions interfering with parenting such as poverty, substance abuse, mental health needs, and domestic violence;

C. Significant relationship disturbance between parent(s); and

D. Child showing significant risk factors for more serious emotional/behavioral challenges (e.g. problems with social relatedness, significant difficulty with affective/behavioral ser-regulation, multiple developmental delays).

(c) Providers shall be certified to provide Intensive Outpatient Services or must refer child or youth who meet criteria for Intensive Outpatient Services to a provider certified as an Intensive Outpatient Services provider under OAR 309-019-0100 through 309-019-0255.

(d) County shall provide or have provided care coordination and, based on family's identified needs, supportive services such as skills training, crisis planning, respite care, and in-home support to families of children who meet criteria for Intensive Outpatient Services.

(e) County shall use community-based and family and child or youth driven decision-making processes in developing the Service Plan as defined in OAR 309-019-0140.

Planning shall include referral to appropriate types of care. When County refers a child or youth to Psychiatric Day Treatment Services (PDTS) as defined in OAR 309-022-0150(70) or Psychiatric Residential Treatment Services (PRTS) as defined in OAR 309-022-0105(71), the County shall submit a written approval for admission to the appropriate PDTS or PRTS provider, as well as the following:

i. Name and contact information of the care coordinator;

ii. List of child and family team members;

iii. The current mental health assessment within the last 60 calendar days;

iv. Service Plan;

v. Other clinical documentation or collateral information.

vi. When County refers a child or youth to OHA for long-term psychiatric care at secure inpatient programs, Secure Children's Inpatient Program (SCIP) or Secure Adolescent Inpatient Program (SAIP) designated by OHA, the following materials shall be forwarded to the OHA designee:

A. All referrals shall include written Psychiatric recommendation for SCIP or SAIP admission;

B. Documentation of the identified mental health provider;

C. Clinical documentation;

D. Care coordinator, child or youth, and family team members; and

E. The Service Plan.

When an Individual has insurance coverage through a third-party resource (TPR), the case manager or a designee from the insurance provider shall be notified and encouraged to attend treatment meetings.

vii. Services shall include care coordination for children and youth referred to PDTS, PRTS, subacute, acute hospitalization, and long-term psychiatric care. Care coordination includes creating linkages to these programs for the purpose of service coordination planning, attending treatment review meetings, and ongoing participation in treatment during the episode of care at the specific PDTS, PRTS, subacute, acute hospital, or long-term psychiatric care program and after care planning.

viii. County shall provide care coordination and other medically appropriate services and make referrals to the appropriate treatment services for children and youth who do not meet criteria for Intensive Outpatient Services or Intensive Treatment Services.

Adult Services:

(a) Provide coordination of care services for Individuals living in residential treatment programs. The coordination of care shall include participation in the residential Provider's treatment planning process and in planning for the Individual's transition to outpatient services;

(b) Comply with Outpatient Services, as described in OAR 309-019-0100 through 309-019-0220, and Community Treatment and Supports, as described in OAR 309-032-0301 through 309-032-0890, as such rules may be revised from time to time; and

(c) Maintain a Certificate of Approval for the delivery of clinical services in accordance with OAR 309-008-0100 through OAR 309-008-1600, as such rules may be revised from time to time.

c. Reporting Requirements

See Exhibit E, 10.

(4) Special Reporting Requirements

(a) The Child and Youth Needs and Strengths (CANS) reporting and analytics system will be used as a tool to identify youth and caregiver needs and strengths, inform service planning, assess success of interventions, and monitor outcomes. County shall report using the CANS system for date and outcomes in a manner prescribed by OHA.

(b) County shall provide a written report to http://www.oregon.gov/OHA/HSD/AMH/Pages/Reporting-Requirements.aspx. within 30 calendar days following the end of the contract period, that shows the total funding spent during the life of the Agreement for both Child and Youth, and for Adults. County shall provide additional follow-up report(s) upon OHA's reasonable request.

(5) Financial Assistance Calculation, Disbursement, and Confirmation of Performance and Reporting Requirements Procedures

See Exhibit D, Payment, Settlement, and Confirmation.

Use Payment and Confirmation language. In addition,

County understands and agrees that funding under Part A or Part C may be reduced by Agreement amendment to the extent County's billings under MMIS for Part B funding exceed the allocated total aggregated budget as set for in Exhibit C, "Financial Assistance Award."

26. Service Name: **ACUTE AND INTERMEDIATE PSYCHIATRIC INPATIENT SERVICES**

Service ID Code: **MHS 24**

a. Service Description

(1) Acute Psychiatric Inpatient Services are inpatient psychiatric Services delivered to Individuals who are uninsured, underinsured, not eligible for Medicaid, or have exhausted Medicaid services, including those who meet the criteria for the Citizen Alien Waived Medical Program; and are suffering from an acute mental illness or other mental or emotional disturbance posing a danger to the health and safety of the Individual or others. The Services are primarily delivered on an inpatient basis and are intended to stabilize, control, or ameliorate acute psychiatric dysfunctional symptoms or behaviors in order to return the Individual to a less restrictive environment at the earliest possible time.

Acute Psychiatric Inpatient Services also include ancillary Services such as regional coordination and enhancements to Community Mental Health Program (CMHP) services that serve to expedite the movement of Individuals into and out of facilities where inpatient psychiatric Services are delivered and to divert Individuals from acute care services.

(2) Intermediate Psychiatric Inpatient Services in this Service Description provide Long-Term Psychiatric Care (LTPC) Services to Individuals in an LTPC acute care hospital who are on a waitlist for admittance to the Oregon State Hospital (OSH). These are Mental Health Services within the scope of ORS 430.630 and OAR 309-091-0000 through 309-091-0050 delivered on a demonstration or emergency basis for a specified period of time.

For LTPC, Coordinated Care Organization (CCO) enrolled means the Individual is enrolled in one of the following CCO designations:

(a) CCOA – Mental Health, Physical Managed Care, and Dental services.

(b) CCOB – Mental Health and Physical Managed Care services.

(c) CCOE – Mental Health services.

(d) CCOG – Mental Health and Dental services.

b. Performance Requirements

(1) Acute Psychiatric Inpatient Services shall be delivered in accordance with ORS 430.630 (3) and (4), and ORS 426.241 (5).

(a) Services may only be delivered to the following Individuals:

i. An Individual in need of emergency hold services under ORS 426.232 and ORS 426.233;

ii. An Individual committed to OHA under ORS 426.130; or

iii. An Individual voluntarily seeking Acute and Intermediate Psychiatric Inpatient Services (MHS 24 Services), provided that service capacity is available and the Individual satisfies one or more of the following criteria:

A. The Individual is at high risk for an emergency hold or civil commitment without voluntary inpatient psychiatric Services;

B. The Individual has a history of psychiatric hospitalization and is beginning to decompensate and for whom a short period of intensive inpatient psychiatric treatment would reverse the decompensation process; or

C. Individual is an appropriate candidate for inpatient psychiatric treatment but other inpatient psychiatric treatment resources are unavailable.

(b) Hospital and Secure Residential Treatment Providers of MHS 24 Services shall comply with OAR 309-015-0000 through 309-015-0060 and OAR 309-035-0100 through 309-035-0225, respectively, as such rules may be revised from time to time.

(c) Facilities used by County or its Providers for Services under MHS 24 Service Description shall maintain certification by the Joint Commission on Accreditation of Health Care Organization (JCAHO) or other nationally recognized accrediting body acceptable to OHA, licensure under ORS 441.015 by the Oregon State Health Division for the hospital services, and comply with the following applicable rules:

i. OAR 309-008-0100 through 309-008-1600 "Behavioral Health Treatment Services"

ii. OAR 309-033-0200 through 309-033-0970 "Involuntary Commitment Proceedings"

iii. OAR 309-032-0301 through 309-032-0890 "Community Treatment and Support Services" Secured Transportation Services under MHS 24 Service Description shall be approved under OAR 309-033-0400 through 309-033-0440, as such rules may be revised from time to time.

(d) Hospital and Secure Residential Treatment Providers of Services under this Agreement shall submit required information to OHA electronically through the Oregon Patient and Resident Care System (OP/RCS) or its replacement, within 12 hours of an Individual's admission to and discharge from the Provider's facility for Services, as outlined in the OP/RCS Manual, located at http://www.oregon.gov/oha/HSD/AMH-MOTS/Pages/resource.aspx.

(2) Intermediate Psychiatric Inpatient Services shall be delivered in accordance with the requirements specified below:

(a) Services shall be delivered to the following Individuals:

i. Individuals who have been determined appropriate for LTPC Services by a representative of OHA but who remain in an intermediate psychiatric care setting pending transfer to intensive psychiatric rehabilitation or other tertiary treatment in an OSH or Extended Care Program;

ii. Individuals who have been determined to be eligible for Services under the Oregon Health Plan (OHP) and are enrolled with a CCO under contract with OHA; and

iii. Individuals who have been determined to be eligible for Services and are entered into the OP/RCS or its successor.

iv. Individuals who have been determined eligible for Services under the OHP but are not enrolled with a CCO on the day of admit for Intermediate Psychiatric Inpatient Services are to be billed through the OHA Medicaid Management Information System on a Fee for Service basis.

(b) Services include, but are not limited to:

i. Intermediate Psychiatric Inpatient Services that provide intensive psychiatric symptom stabilization; and

ii. Rehabilitative interventions include, but are not limited to therapy, medications, skills training, and mental health assessments or consultations.

(c) Notwithstanding the requirements above, OHA will provide financial assistance to County for the cost of Services, from the date of the LTPC determination until the date of discharge to LTPC, for Individuals enrolled with a CCO on the date of the LTPC determination and for Individuals who are dis-enrolled from the CCO prior to transfer to LTPC.

(d) Requests for LTPC for Individuals who are hospitalized and who require additional psychiatric inpatient care beyond the acute psychiatric care Service for which the CCO is responsible, must be reviewed by OHA.

(e) Appropriate candidates for LTPC are Individuals who meet the specific criteria as determined by OHA for either intensive psychiatric rehabilitation or other tertiary treatment in a State Hospital or extended and specialized medication adjustment in a secure or otherwise highly supervised environment.

(f) When an Individual is ultimately determined to be an appropriate candidate for LTPC, the effective date of determination shall be:

i. The date OHA receives from the CCO a complete LTPC referral packet. A complete referral packet must include:

A. A "Request of Long Term Psychiatric Care Determination" form, signed by the authorized CCO representative;

B. Documentation that the Individual is civilly committed and has a permanent Guardian or Attorney-in-fact (ORS 127.505 through 127.660); and

C. Clinical documentation including, but not limited to, Physician's History and Physical, Psychosocial History, labs and other testing, consultation documentation from medical and psychiatric providers, progress notes from psychiatrist(s) (and other physician(s)), nurse(s), social worker(s), and other therapist(s) involved in current episode of care; or

ii. A mutually agreed upon date by OHA and the CCO, if the OHA date of receipt (identified above as date of determination) cannot be firmly established.

(g) Ineligibility:

i. Individuals who are not OHP enrollees of a CCO upon hospitalization in LTPC Services are ineligible for financial assistance.

ii. Individuals who are dually or singly eligible Medicare or private/employee-based health care covered Individuals are ineligible for financial assistance.

(h) OHA reserves the right to re-determine if an Individual meets the eligibility qualifications for LTPC. If a re-determination results in the Individual no longer meeting the LTPC criteria, as determined by OHA, the days remaining for the Individual may no longer be eligible for financial assistance. Notification of determination and re-determination will be provided to County in written form, including rationale for the decision(s).

(i) OHA will provide financial assistance for Services for OHP-CCO enrolled members (Individuals) determined appropriate for such care beginning on the effective date of such determination as established above, until the time that the Individual is discharged from such setting.

(j) OHA will not be responsible for providing financial assistance for Services when OHA determines that an OHP-CCO enrolled member (Individual) is not appropriate for LTPC and denies the CCO's request for LTPC.

(k) OHA retains all rights regarding final determination of an Individual's eligibility for Services.

c. **Special Reporting Requirements**

Reports must be prepared using forms and procedures prescribed by OHA. Forms are located at http://www.oregon.gov/OHA/HSD/AMH/Pages/Reporting-Requirements.aspx.

(1) Acute Psychiatric Inpatient Services:

County shall submit electronically, to amhcontract.administrator@state.or.us, an annual accounting report of financial assistance by August 31st for the prior state fiscal year.

(2) Intermediate Psychiatric Inpatient Services:

Hospital and Secure Residential Treatment Providers of Services under this Agreement must submit required information to OHA electronically, through the Oregon Patient and Resident Care System (OP/RCS), within 12 hours of an Individual's admission to and discharge from the Provider's facility for Services, as outlined in the OP/RCS Manual, located at http://www.oregon.gov/oha/HSD/AMH-MOTS/Pages/resource.aspx.

d. **Financial Assistance Calculation, Disbursement Procedures, and Confirmation of Performance and Reporting Requirements:**

See Exhibit D, Payment, Settlement, and Confirmation Requirements.

Use Payment and Confirmation language.

In addition:

(1) Acute Psychiatric Inpatient Services

Use Part A payment language.

(2) Intermediate Psychiatric Inpatient Services

The Part C awards will be calculated, disbursed, and confirmed as follows:

(a) Calculation of Financial Assistance:

OHA will provide financial assistance to County at $834.61 per day, per authorized Individual. OHA is not obligated to pay County for expenditures beyond the limitation for the identified period of this Agreement. OHA will make monthly allotments from invoices, after OHA's receipt, review, and approval of such invoices. All allotments made by OHA are subject to the limitation described herein.

(b) Disbursement of Financial Assistance:

i. Invoices shall be submitted electronically, to amhcontract.administrator@state.or.us, with the subject line "Invoice, contract #(your contract number), contractor's name" on an OHA approved invoice, and at the level of detail prescribed by OHA no later than 60 calendar days after the Individual's last date of Services.

ii. All payments made to County under this Agreement are subject to recovery by OHA as follows:

A. If an audit of the Services rendered by County under this Agreement, whether directly or through subcontract(s), results in a refund to or disallowance by the federal government of payment made to County under this Agreement, OHA may recover from County the amount of the refund or disallowance and any applicable OHA matching funds.

B. If County expends funds awarded to County under this Agreement for unauthorized expenditures, OHA may recover from County the full amount of unauthorized expenditures.

iii. In the event funds awarded to County under this Agreement are subject to recovery as described above, OHA may, at its option, upon written notice to County:

A. Offset the amount subject to recovery against other funds due County from OHA under this Agreement or otherwise; or

B. Demand that County pay to OHA the amount subject to recovery, in which case County shall immediately pay said amount to OHA. Nothing in this section will affect OHA's right to terminate this Agreement as set forth in Exhibit G, "Standard Terms and Conditions," or any remedies otherwise available to OHA as a result of the termination of this Agreement.

iv. Upon 30 calendar days advance written notice to County, OHA may withhold financial assistance otherwise due County under this Agreement if County fails to submit required reports when due or fails to perform or document the performance of Services under this Agreement. Immediately upon written notice to County, OHA may withhold financial assistance if County or its Provider(s) no longer holds all licenses, certificates, letters of approval, or certificate of approval that are required to perform the Services. Withholding of financial assistance may continue until County submits the required reports or performs the required Services. Nothing in this section will affect OHA's right to terminate this Agreement as set forth in Exhibit F, "Standard Terms and Conditions," or any remedies otherwise available to OHA as a result of the termination of this Agreement.

v. OHA will not provide financial assistance in excess of the maximum compensation amount set forth in this Agreement. If this maximum compensation amount is increased by amendment of this Agreement, the amendment must be fully effective before County or its Provider(s) performs Services subject to the amendment. No financial assistance will be provided for any Services performed before the beginning date or after the expiration date of this Agreement, as it may be amended from time to time in accordance with its terms.

27. **Service Name:** **COMMUNITY CRISIS SERVICES FOR ADULTS AND CHILDREN**

Service ID Code: **MHS 25**

a. **Service Description**

(1) Purpose:

Community Crisis Services for Adults and Children (MHS 25 Services) are immediately available mental health crisis assessment, triage, and intervention Services delivered to Individuals experiencing the sudden onset of psychiatric symptoms or the serious deterioration of mental or emotional stability or functioning. MHS 25 Services are of limited duration and are intended to stabilize the Individual and prevent further serious deterioration in the Individual's mental status or mental health condition.

(2) Definitions:

(a) **Care Coordination** means a process-oriented activity to facilitate ongoing communication and collaboration to meet multiple needs. Care Coordination includes facilitating communication between the family, natural supports, community resources, and involved Providers for continuity of care by creating linkages to and managing transitions between levels of care and transitions for young adults in transition to adult services.

(b) **Community-based** means that Services and supports must be provided in an Individual's home and surrounding community and not solely based in a traditional office-setting.

(c) **Crisis** means either an actual or perceived urgent or emergent situation that occurs when an Individual's stability or functioning is disrupted and there is an immediate need to resolve the situation to prevent a serious deterioration in the Individual's mental or physical health or to prevent referral to a significantly higher level of care.

(d) **Crisis Line Services** means phone-based Services that establish immediate communication links and provide supportive interventions and information for Individuals in an urgent or emergent situation.

(e) **Mobile Crisis Response Time** means the time from the point when a professional decision is made that a face-to-face intervention is required, to the time the actual face-to-face intervention takes place in the community.

(f) **Mobile Crisis Services** means Mental Health Services for Individuals in Crisis, provided by mental health practitioners who respond to behavioral health Crises onsite at the location in the community where the Crisis arises and who provide a face-to-face therapeutic response. The goal of Mobile Crisis Services is to help an Individual resolve a psychiatric crisis in the most integrated setting possible, and to avoid unnecessary hospitalization, inpatient

psychiatric treatment, involuntary commitment, and arrest or incarceration.

(g) **Screening** means the process to determine whether the Individual needs further assessment to identify circumstances requiring referrals or additional Services and supports.

(h) **Service Plan** means a comprehensive plan for Services and supports provided to or coordinated for an Individual and his or her family, per OAR 309-019-0105104) as applicable, that is reflective of the assessment and the intended outcomes of Service.

(3) MHS 25 Services shall include, but are not limited to, the following:

(a) Provide Crisis Services to 24 hours a day, 7 days a week face-to-face or telephone Screening to determine the need for immediate Services for any Individual requesting assistance or for whom assistance is requested;

(b) A mental health assessment concluding with written recommendations by a Qualified Mental Health Professional or a Qualified Mental Health Associate, as defined in OAR 309-019-0105(94) QMHP and (95) QMHA, regarding the need for further treatment;

(c) Provide brief Crisis intervention;

(d) In the case of a child, appropriate child and family psychological, psychiatric, and other medical interventions delivered by or under the direct supervision of a Qualified Mental Health Professional, that are specific to the assessment and identified in the initial treatment plan, and any community placements necessary to protect and stabilize the child as quickly as possible;

(e) In the case of an adult, appropriate psychological, psychiatric, and other medical interventions delivered by or under the direct supervision of a Qualified Mental Health Professional, that are specific to the assessment and identified in the initial treatment plan, and any community placements necessary to protect and stabilize the Individual as quickly as possible;

(f) Connect the Individual with ongoing Services and supports;

(g) Arrangement for the provision of involuntary psychiatric Services at a hospital or non-hospital facility approved by OHA, when an Individual's behavior requires it;

(h) Crisis Line Services shall be provided in accordance with OAR 309-019-0300 through 309-019-0320; and

(i) Mobile Crisis Services:

The effectiveness of Mobile Crisis Services in de-escalating a Crisis and diverting hospitalization or arrest is enhanced by team members competent in performing an assessment and delivering an effective course of intervention. These Services provide access to a multi-disciplinary support team and ready resources, such as access to

urgent appointments, brief respite services, and the ability to provide brief follow-up care when indicated.

County shall provide Mobile Crisis Services according to OAR 309-019-0151 including, but not limited to:

i. 24 hours a day, 7 days a week capability to conduct a face-to-face mental health status examination of an Individual by a Qualified Mental Health Professional (QMHP) (in accordance with OAR 309-019-0125(10) or Qualified Mental Health Associate (QMHA) (in accordance with OAR 309-019-0125(9)) under the supervision of a QMHP. Examination is used to determine the Individual's condition and the interventions necessary to stabilize the Individual and the need for immediate Services for any Individual requesting assistance or for whom assistance is requested;

ii. A face-to-face therapeutic response delivered in a public setting at locations in the community where the Crisis arises including, but not limited to, an Individual's home, schools, residential programs, nursing homes, group home settings, and hospitals to enhance community integration;

iii. Services that are generally delivered in a natural environment by or under the supervision of a QMHP, such as QMHAs and peers, and resulting in a Service Plan. Disposition of Services shall maintain as the primary goal with diversion from hospitalization and incarceration through clinically appropriate Community-based supports and Services;

iv. County shall respond to Crisis events in its respective geographic service area with the following maximum response times:

- **A.** Counties classified as "urban" shall respond within 1 hour.
- **B.** Counties classified as "rural" shall respond within 2 hours.
- **C.** Counties classified as "frontier" shall respond within 3 hours.
- **D.** Counties classified as "rural" and "frontier" shall contact an Individual experiencing a Crisis event via telephone by a staff member who is trained in crisis management (such as a person from a crisis line or a peer) within 1 hour from the initial Crisis call.

v. Eliminating the need for transportation (frequently provided by law enforcement officers or emergency services) to a hospital's emergency department or a community crisis site;

vi. Are not intended to be restricted to services delivered in hospitals or at residential programs;

vii. Mental Health Crisis assessment;

viii. Brief Crisis intervention;

ix. Assistance with placement in crisis respite or residential services;

x. Initiation of commitment process, if applicable;

xi. Assistance with hospital placement;

xii. Connecting Individuals with ongoing supports and Services; and

xiii. Coordination with Crisis Line Services providers to support seamless transitions of care.

(j) Provide disaster response, Crisis counseling Services to include:

i. Responding to local disaster events by:

A. Providing Crisis counseling and critical incident stress debriefing to disaster victims; police, firefighters and other "first-responders"; disaster relief shelters; and the community-at-large.

B. Coordinating Crisis counseling Services with County Emergency Operations Manager (CEOM); and providing Crisis counseling and stress management Services to Emergency Operations Center staff according to agreements established between the CMHP and CEOM.

ii. Assisting CMHP's in the provision of these Services as part of a mutual aid agreement; and

iii. For the purpose of responding to a specified local disaster event, payment may be made through an amendment to the Financial Assistance Award for these Services.

b. **Performance Requirements**

(1) County shall comply with OAR 309-019-0100 through 309-019-0320, as such rules may be revised from time to time.

(2) County shall maintain a Certificate of Approval in accordance with OAR 309-008-0100 through 309-008-1600, as such rules may be revised from time to time.

c. **Reporting Requirements**

See Exhibit E, 10.

d. Special Reporting Requirements

County shall prepare and electronically submit, to amhcontract.administrator@state.or.us, written quarterly summary reports on the delivery of Mobile Crisis Services, no later than 45 calendar days following the end of each subject quarter for which financial assistance is awarded through this Agreement. Reports must be prepared using forms and procedures prescribed by OHA. Forms are located at http://www.oregon.gov/OHA/HSD/AMH/Pages/Reporting-Requirements.aspx.

Each quarterly report shall include, but is not limited to the following :

(1) Individual's name;

(2) Gender;

(3) Date of birth;

(4) Medicaid identification number (if applicable)

(5) Race;

(6) Ethnicity;

(7) Location of Mobile Crisis Service

(8) Disposition of the Mobile Crisis contact;

(9) Mobile Crisis Response Time; and

(a) Response time begins from the point when a professional decision is made that a face-to-face intervention is required.

(b) Response time ends when the actual face-to-face intervention takes place in the community between the Individual and the mental health practitioner.

(10) Reason for exceeding maximum response time (if applicable).

e. Financial Assistance Calculation, Disbursement, and Confirmation of Performance and Reporting Requirements Procedures

See Exhibit D, Payment, Settlement, and Confirmation Requirements.
Use Payment and Confirmation language.
In addition:

The Part C financial assistance does not apply to PSRB Individuals, as these Services are covered in the Service Description for MHS 30.

28. **Service Name:** **NON-RESIDENTIAL MENTAL HEALTH SERVICES FOR YOUTH & YOUNG ADULTS IN TRANSITION**

Service ID Code: **MHS 26**

a. Service Description

Non-Residential Mental Health Services for Youth & Young Adults in Transition (MHS 26 Services) are Mental Health Services delivered to Individuals through 25 years of age who are under the jurisdiction of the Juvenile Panel of the Psychiatric Security Review Board (JPSRB) or are considered Young Adults in Transition (YAT) , as specified in Exhibit C, "Financial Assistance Award," and have behavioral health needs posing a danger to the health and safety of themselves or others. The purpose of MHS 26 Services is to provide mental health services in community settings that reduce or ameliorate the disabling effects of behavioral health needs. Non-Residential Mental Health Services for Youth & Young Adults in Transition include:

(1) Care coordination and residential case management services;

(2) Vocational and social services;

(3) Rehabilitation;

(4) Support to obtain and maintain housing (non-JPSRB only);

(5) Abuse investigation and reporting;

(6) Medication (non-JPSRB only) and medication monitoring;

(7) Skills training;

(8) Mentoring;

(9) Peer support services;

(10) Emotional support;

(11) Occupational therapy;

(12) Recreation;

(13) Supported employment;

(14) Supported education;

(15) Secure transportation (non-JPSRB only);

(16) Individual, family and group counseling and therapy;

(17) Rent Subsidy (non-JPSRB only); and

(18) Other services as needed for Individuals, at the sole discretion of OHA.

b. Performance Requirements

(1) Services to Individuals through 25 years of age under the jurisdiction of the JPSRB or are considered Young Adults In Transition (YAT) must be delivered with the least possible disruption to positive relationships and must incorporate the following:

(a) The rapport between professional and Individual will be given as much of an emphasis in Service planning as other case management approaches;

(b) Services will be coordinated with applicable adjunct programs serving both children and adults, so as to facilitate smoother transitions and improved integration of Services and supports across both adolescent and adult systems;

(c) Services will be engaging and relevant to youth and young adults;

(d) Services will accommodate the critical role of peers and friends;

(e) The treatment plan will include a safety component to require that identity development challenges and boundary issues are not cause for discontinuing Service;

(f) The "Service Plan" will include a specific section addressing Services and supports unique to the developmental progress of Youth and Young Adults in Transition including school completion, employment, independent living skills, budgeting, finding a home, making friends, parenting and family planning, and delinquency prevention;

(g) The OHA Young Adult Service Delivery Team or its designee shall provide direction to Provider regarding Services to be delivered to the youth or young adult; and

(h) Secured transportation services under the "Service Description" section for MHS 26 Services will be approved by OHA on a case by case basis.

(2) Required non-JPSRB Services that are not otherwise covered by another resource will be funded at the Medicaid Fee Schedule rate as a basis for disbursement purposes. Disbursements will be made by invoice in accordance with the "Financial Assistance Calculation, Disbursement, and Agreement Settlement Procedures" section below. Approved Services may include one or more of the following:

(a) Additional staffing;

(b) Transportation;

(c) Interpreter services;

(d) Medical services and medications;

(e) Rental assistance, room and board, and personal incidental funds; or

(f) Non-medically approved services including, but not limited to, assessment, evaluation, outpatient treatment, and polygraph.

c. Reporting Requirements

See Exhibit E, 10.

d. Special Reporting Requirements

County shall prepare and electronically submit, to amhcontract.administrator@state.or.us, written quarterly reports, no later than 45 calendar days following the end of each subject quarter for which financial assistance is awarded through this Agreement. Reports must be prepared using forms and procedures prescribed by OHA. Forms are located at http://www.oregon.gov/OHA/HSD/AMH/Pages/Reporting-Requirements.aspx.

There shall be a report from each Young Adult Residential Treatment Program providing Services under this Agreement within the County (or one report that breaks out each separate entity) for data subject to that specific quarter. Each report shall include the following components:

(1) Number admitted;
(2) Number transitioning;
(3) Number and nature of program supports provided to all residents;
(4) Percentage change in residents' feelings of well-being, support and connectivity;
(5) Type and number of community-based supports residents accessed or participated in; and
(6) Type and number of goals accomplished by residents.

In addition, all programs for which financial assistance is awarded through this Agreement shall administer the Adult Hope Scale, located at https://ppc.sas.upenn.edu/sites/ppc.sas.upenn.edu/files/hopescale.pdf to each Individual and include the results on the quarterly report. Counties providing both MHS 26 and MHS 27 Services need only provide one report for both Services.

e. Financial Assistance Calculation, Disbursement, and Confirmation of Performance and Reporting Requirements Procedures

See Exhibit D, Payment, Settlement, and Confirmation requirements.

Use Payment and Confirmation language.

In addition:

(1) County understands and agrees that funding under Part A or Part C may be reduced by Agreement amendment to the extent Counties billings under MMIS for Part B funding exceed the allocated total aggregated budget as set for in Exhibit C, "Financial Assistance Award".

29. **Service Name:** **RESIDENTIAL MENTAL HEALTH TREATMENT SERVICES FOR YOUTH & YOUNG ADULTS IN TRANSITION**

Service ID Code: **MHS 27**

a. **Service Description**

(1) Residential Mental Health Treatment Services for Youth & Young Adults in Transition (MHS 27 Services) are mental health Services delivered to Individuals 17 through 24 years of age in a group residential setting to enable the Individual to acquire sufficient stability and connectivity to the community to enable them to live as independently as they choose. These are Individuals who are under the jurisdiction of the Juvenile Panel of the Psychiatric Security Review Board (JPSRB), and are transitioning from an institutional setting, or in need of a structured and supportive transitional living environment. This includes Individuals without insurance or those who are under-insured. Programs are expected to maximize this funding to enhance an Individuals' likelihood of living independently in the community through the provision of the Services listed in MHS 27.

(2) Individuals eligible for these Services are those that the OHA's Young Adult Coordinator or designee determines are unable to live independently at the time of the referral, without supervised intervention, training, or support.

(3) Services are delivered on a 24-hour basis to Individuals with mental or emotional disorders who have been hospitalized or are at immediate risk of hospitalization, who need continuing services to avoid hospitalization, or who are a danger to themselves or others, or who otherwise require transitional care to remain in the community.

(4) These Services have no time line. It is expected that they will be used to help the Individual connect to ongoing, longer-term supports, meet their needs and goals, and support them in moving toward a positive life trajectory.

(e) It is preferable that the peer support specialist and the clinical staff meet with the Individual together during the initial contact, or soon thereafter. Contacts should be as frequent as is necessary for the goals of the project to occur, but no less than twice per week.

(f) MHS 27 Services shall be delivered in appropriately licensed and certified programs or facilities and include, but are not limited to, the following:

(a) Crisis stabilization services, such as accessing psychiatric, medical, or qualified professional intervention to protect the health and safety of the Individual and others;

(b) Timely, appropriate access to crisis intervention to prevent or reduce acute, emotional distress, which might necessitate psychiatric hospitalization;

(c) Money and household management;

(d) Supervision of daily living activities such as skill development focused on nutrition, personal hygiene, clothing care and grooming, and communication skills for social, health care, and community resources interactions;

(e) Provision of care including the assumption of responsibility for the safety and well-being of the Individual;

(f) Administration, supervision, and monitoring of prescribed and non-prescribed medication and client education on medication awareness;

(g) Provision or arrangement of routine and emergency transportation;

(h) Developing skills to self-manage emotions;

(i) Management of a diet, prescribed by a physician, requiring extra effort or expense in preparation of food;

(j) Management of physical or health problems including, but not limited to, diabetes and eating disorders;

(k) Skills training;

(l) Mentoring, peer delivered services, and peer support services;

(m) Positive use of leisure time and recreational activities;

(n) Supported education;

(o) Supported employment;

(p) Occupational therapy; and

(q) Recreation.

b. **Performance Requirements**

(1) Services to Youth & Young Adults in Transition shall be delivered with the least possible disruption to positive relationships and shall incorporate the following principles and practices:

(a) The rapport between professional and Individual will be given as much of an emphasis in Service planning as other case management approaches;

(b) Services will be coordinated with applicable adjunct programs serving both children and adults so as to facilitate smoother transitions and improved integration of Services and supports across both adolescent and adult systems;

(c) Services will be engaging and relevant to Youth & Young Adults in Transition;

(d) Services will accommodate the critical role of peers and friends;

(e) The individual service and support plan will include a safety component to require that identity development challenges and boundary issues are not cause for discontinuing Service;

(f) The individual service and support plan will include a specific section addressing Services and supports unique to the developmental progress of Youth & Young Adults in Transition, including school completion, employment, independent living skills, budgeting, finding a home, making friends, parenting and family planning, and delinquency prevention; and

(g) Staff working in the programs must have training in suicide prevention and intervention strategies and Trauma Informed Care and be provided with ongoing maintenance of the skills and practice associated with these approaches.

(2) Services to JPSRB or Youth & Young Adults in Transition shall be delivered in support of the conditional release plan as set forward by the JPSRB Board.

(3) Providers of MHS 27 Services funded through this Agreement shall comply with OAR 309-035-0100 through 309-035-0190, as such rule may be revised from time to time.

(4) Providers of MHS 27 Services funded though this Agreement shall maintain a Certificate of Approval in accordance with OAR 309-008-0200 through 309-008-1100.

c. **Reporting Requirements**

See Exhibit E, 10.

d. **Special Reporting Requirements**

(a) County shall prepare and electronically submit, to amhcontract.administrator@state.or.us, the following written reports using forms and procedures prescribed on OHA's website located at http://www.oregon.gov/OHA/HSD/AMH/Pages/Reporting-Requirements.aspx.

i. A quarterly report that includes the following elements per each Young Adult Residential Treatment Program per subject quarter:

A Number admitted;
B Number transitioning;
C Number and nature of program supports provided to all Individuals;
D Percentage change in Individuals' feelings of well-being, support and connectivity;
E Type and number of community-based supports Individuals accessed or participated in; and
F Type and number of goals accomplished by Individuals.

ii. In addition, all programs shall administer the Adult Hope Scale located at https://ppc.sas.upenn.edu/sites/default/files/hopescale.pdf as an outcome measurement tool.

(b) County shall complete and deliver to OHA the Personal Care Data Form For Residential Facilities for any Individual receiving MHS 27 Services funded through this Agreement when the Individual is transferred to another residence or facility operated by the Provider, the Individual is transferred

to another Provider of MHS 27 Services, MHS 27 Services to the Individual end, or the payment rate for the Individual changes. An Individual's payment rate may only be changed after consultation with and approval by OHA.

e. Financial Assistance Calculation, Disbursement, and Agreement Settlement Procedures

See Exhibit D, Payment, Settlement, and Confirmation Requirements.

Use Payment and Settlement language.

In addition:

(a) County understands and agrees that funding under Part A or Part C may be reduced by Agreement amendment to the extent Counties billings under MMIS for Part B funding exceed the allocated total aggregated budget as set for in Exhibit C, "Financial Assistance Award:.

30. **Service Name:** **RESIDENTIAL TREATMENT SERVICES**
Service ID Code: **MHS 28**

a. **Service Description**

(1) Residential Treatment Services (MHS 28) are:

(a) Services delivered on a 24-hour basis to Individuals who are uninsured, underinsured, not eligible for Medicaid, or have exhausted Medicaid services, including those who meet the criteria for Citizen Alien Waived Medical Program. Individuals must be 18 years of age or older with mental or emotional disorders, who have been hospitalized or are at immediate risk of hospitalization, who need continuing Services to prevent hospitalization or who are a danger to themselves or others, or who otherwise requires continuing care to maintain stability and learn skills needed to be placed in a more integrated community setting; and

(b) Services delivered to Individuals that OHA determines are currently unable to live independently without supervised intervention, training, or support.

The specific MHS 28 Services delivered to an Individual are determined based upon a person-centered assessment of treatment needs and the development of a Plan of Care that is individualized to promote stabilization, skill building, and preparation to be living in a more integrated community.

(2) MHS 28 Services delivered in Residential Treatment Facilities (RTF), as defined in OAR 309-035-0105, Residential Treatment Homes (RTH), as defined in OAR 309-035-0105, or another licensed setting approved by OHA include, but are not limited to, the following:

(a) Crisis stabilization services such as accessing psychiatric, medical, or qualified professional intervention to protect the health and safety of the Individual and others;

(b) Timely, appropriate access to crisis intervention to prevent or reduce acute emotional distress, which might necessitate psychiatric hospitalization;

(c) Management of personal money and expenses;

(d) Supervision of daily living activities and life skills, such as training in nutritional wellness, personal hygiene, clothing care and grooming, communication with social skills, health care, household management, and using community resources to support increasing independence and preparation for living in the most integrated community environment;

(e) Provision of care including assumption of responsibility for the safety and well-being of the Individual;

(f) Administration and supervision of prescribed and non-prescribed medication(s);

(g) Provision of or arrangement for routine and emergency transportation;

(h) Management of aggressive or self-destructive behavior;

(i) Management of a diet, prescribed by a physician, requiring extra effort or expense in preparation of food; and

(j) Management of physical or health problems including, but not limited to, seizures, incontinency, diabetes, and pain management.

Financial assistance is dependent upon the Individual served meeting defined criteria as cited in OAR 410-172-0630 and OAR 309-035-0200. OHA and its designees have the authority to review clinical records and have direct contact with Individuals. The County and any Providers shall notify Individuals in writing of admission decisions in accordance with OAR 309-035-0163(10).

b. Performance Requirements

A Provider of MHS 28 Services shall give first priority in admission to referrals for Individuals transitioning from the Oregon State Hospital (OSH); second priority to referrals for Individuals on the OSH wait list or in acute care psychiatric hospitals; and then to all others.

A Provider of MHS 28 Services funded through this Agreement shall deliver MHS 28 Services in a facility licensed as a RTH, a RTF or Secured Residential Treatment Facility (SRTF), in accordance with OAR 309-035-0100 through 309-035-0225, as such rules may be revised from time to time.

Other required, approved Services for civil commitment (non-PSRB) Individuals who are not otherwise covered by another resource will be funded at the Medicaid Fee Schedule Rate. Disbursement will be made by invoice in accordance with the "Financial Assistance Calculation, Disbursement, and Agreement Settlement Procedures" section below. Approved Services may include one or more of the following:

(1) Additional staffing;

(2) Interpreter services;

(3) Medical services and medications;

(4) Rental assistance for Individuals not covered by Medicaid for reasons such as a PSRB Individual who is not Medicaid-eligible, or an Individual who is Medicaid-eligible but whose funding has not yet started; room and board; and personal and incidental funds; and

(5) Non-medically approved services including but not limited to assessment, evaluation, and outpatient treatment.

c. Reporting Requirements

See Exhibit E, 10.

d. Special Reporting Requirements

(1) If County has authorized or anticipates authorizing delivery of MHS 28 Services to an Individual and wishes to reserve MHS 28 Service capacity as defined in OAR 309-011-0115(3), up to a maximum of 30 calendar days for that Individual while the Individual is not actually receiving MHS 28 Services, County shall submit a written Reserved Service Capacity Payment (RSCP) request and a CAR to OHA under OAR 309-011-0105 through 309-011-0115. If OHA approves the RSCP request and the CAR for a non-Medicaid-eligible Individual, OHA and County shall execute an amendment to the Financial Assistance Award to reduce residential funding, and add funds necessary to make the approved disbursements to reserve the service capacity. If the Individual is Medicaid-eligible, OHA and County shall execute an amendment to the Financial Assistance Award to add funds necessary to make the approved disbursements to reserve the service capacity. OHA shall have no obligation to make the disbursements unless and until the Financial Assistance Award has been so amended.

e. Financial Assistance Calculation, Disbursement, and Agreement Settlement Procedures

See Exhibit D, Payment, Settlement, and Confirmation Requirements.

Use Payment and Settlement language.

In addition:

County understands and agrees that funding under Part A or Part C may be reduced by Contract amendment to the extent County's billings under MMIS for Part B payments exceed the allocated total aggregated budget as set for in Exhibit C, "Financial Assistance Award." Agreement, termination of OHA's The Part C awards do not apply to PSRB Individuals, as these Services are covered in the Service Description for MHS 30.

31. **Service Name:** **MONITORING, SECURITY, AND SUPERVISION SERVICES FOR INDIVIDUALS UNDER THE JURISDICTION OF THE ADULT AND JUVENILEPANELS OF THE PSYCHIATRIC SECURITY REVIEW BOARD**

Service ID Code: **MHS 30**

a. **Service Description**

Monitoring, Security, and Supervision Services for Individuals under the Jurisdiction of the Adult and Juvenile Panels of the Psychiatric Security Review Board (PSRB & JPSRB) (MHS 30 Services). MHS 30 Services are delivered to Individuals who are placed in their identified service area by Order of Evaluation or Conditional Release Order as designated by OHA.

(1) Monitoring Services include:

(a) Assessment and evaluation for the court, and the PSRB or JPSRB of an Individual under consideration for placement on a waiting list or for Conditional Release from the Oregon State Hospital (OSH), a hospital, jail, or facility designated by OHA, to determine if the Individual can be treated in the community, including identification of the specific requirements for the community placement of an Individual;

(b) Supervision and urinalysis drug screen consistent with the requirements of the PSRB or JPSRB Conditional Release Order;

(c) Coordination with OSH, a hospital, or facility designated by OHA on transition activities related to Conditional Release of an Individual;

(d) Provide supported housing and intensive case management for identified programs at approved budgeted rates; and

(e) Administrative activities related to the Monitoring Services described above, including but not limited to:

i. Reporting of the Individual's compliance with the conditional release requirements, as identified in the order for Conditional Release, as identified in the Order for Conditional Release, through monthly progress notes to the PSRB or JPSRB;

ii. Providing interim reports for the purpose of communicating current status of an Individual to the PSRB or JPSRB;

iii. Submitting requests for modifications of Conditional Release Orders to the PSRB or JPSRB;

iv. Implementing board-approved modifications of Conditional Release Orders;

v. Implementing revocations of Conditional Release due to violation(s) of Conditional Release Orders and facilitating readmission to OSH;

vi. Responding to Law Enforcement Data System (LEDS) notifications as a result of contact by the Individual receiving MHS 30 Services with law enforcement agencies; and

vii. An annual comprehensive review of supervision and treatment Services to determine if significant modifications to the Conditional Release Order should be requested from the PSRB or JPSRB.

(2) Security and Supervision Services includes:

(a) Security Services include: Services identified in the PSRB or JPSRB Conditional Release Order, which are not medically approved Services but are required for safety of the Individual and the public, and are covered at a rate based on a determination of the risk and care needs, as identified in the Security Services Matrix below:

Security Services Matrix	Low Risk	Med Risk	High Risk
High Care	Rate 1	Rate 2	Rate 3
Med Care	Rate 2	Rate 3	Rate 4
Low Care	Rate 3	Rate 4	Rate 5

(b) Supervision Services include approved Services that are not covered by another resource and will be funded at the current Medicaid Fee Schedule rate as a basis for reimbursement purposes. Disbursement will be made by invoice in accordance with the "Financial Assistance Calculation, Disbursement, and Agreement Settlement Procedures" section below. Approved Supervision Services may include one or more of the following:

i. Additional staffing;

ii. Transportation;

iii. Interpreter services;

iv. Medical services and medications;

v. Rental assistance, room and board, and person and incidental funds;

vi. Payee

vii. Guardianship (initial and ongoing) costs;

viii. To obtain legal identification for Individuals receiving supported housing and intensive case management services as identified in Monitoring Services section above; and

ix. Non-medically approved services including, but not limited to: assessment, evaluation, outpatient treatment, and polygraph.

b. **Performance Requirements**

(1) Providers of MHS 30 Services funded through this Agreement shall comply with OAR 309-019-0160, as such rule may be revised from time to time.

(2) Providers of MHS 30 Services funded through this Agreement shall maintain a Certificate of Approval in accordance with OAR 309-008-0100 through OAR 309-008-1600, as such rules may be revised from time to time.

c. **Reporting Requirements**

See Exhibit E, 10.

32. Service Name: **ENHANCED CARE AND ENHANCED CARE OUTREACH SERVICES**

Service ID Code: **MHS 31**

a. Service Description

Enhanced Care and Enhanced Care Outreach Services (MHS 31) enable an Individual to leave, or avoid placement in, the Oregon State Hospital (OSH). MHS 31 Services are outpatient community mental health and psychiatric rehabilitation Services delivered to Individuals who are Department of Human Services (DHS), Adults and People with Disabilities (APD) service need eligible and who have been diagnosed with a severe mental illness with complex behaviors and require intensive community mental health services for successful integration into the community.

b. Performance Requirements

(1) Providers of MHS 31 Services funded through this Agreement shall comply with OAR 309-019-0155, as such rule may be revised from time to time.

(2) Providers of MHS 31 Services funded through this Agreement shall maintain a Certificate of Approval in accordance with OAR 309-008-0100 through 309-008-1600, as such rules may be revised from time to time.

(3) MHS 31 Services funded through this Agreement may only be delivered to Individuals who satisfy the requirements for receipt of nursing facility or community based care under Medicaid, as specified in OAR 411-015-0000 through 411-015-0100, as such rules may be revised from time to time, and who receive such services in a nursing facility, residential care facility, assisted living facility, or foster home operated by a Provider that has entered into an agreement with and is licensed by DHS's APD Division to provide services to designated individuals. All Individuals shall be evaluated by the Provider and local DHS APD licensed facility staff prior to placement.

(4) If County wishes to use MHS 31 funds made available through this Agreement for delivery of MHS 31 Services to otherwise eligible Individuals not residing in a DHS APD facility, County shall receive a variance from OHA in accordance with OAR 309-008-1600, as such rules may be revised from time to time.

(5) County shall notify the OHA ECS Coordinator prior to transition from ECS. County shall also notify the OHA ECS Coordinator within three working days of any change in an Individual's medical or psychiatric condition, which jeopardizes the placement.

c. **Reporting Requirements**

See Exhibit E, 10.

d. **Special Reporting Requirements**

County shall prepare and electronically submit, to amhcontract.administrator@state.or.us, the following reports using forms and procedures as prescribed on OHA's website, located at http://www.oregon.gov/OHA/HSD/AMH/Pages/Reporting-Requirements.aspx.:

(1) Monthly Enhanced Care Services Census Report;

(2) ECS Data Base Part I; and

(3) ECS Data Base Part II.

e. **Financial Assistance Calculation, Disbursement, and Confirmation of Performance and Reporting Requirements Procedures**

See Exhibit D, Payment, Settlement, and Confirmation Requirements.

Use Payment and Confirmation language.

In addition:

County understands and agrees that funding under Part A or Part C may be reduced by Contract amendment to the extent County's fillings under MMIS for Part B payments exceed the allocated total aggregated budget as set for in Exhibit C, "Financial Assistance Agreement."

33. **Service Name:** **ADULT FOSTER CARE SERVICES**
Service ID Code: **MHS 34**

a. **Service Description**

Adult Foster Care Services (MHS 34) are Services delivered to Individuals with chronic or severe mental illness who are in need of further stabilization in a licensed care setting for the potential of transitioning to an *integrated setting*. These Individuals have been hospitalized or are at immediate risk of hospitalization, are in need of continuing Services to avoid hospitalization, or pose a danger to the health and safety of themselves or others, and are unable to live by themselves without supervision. MHS 34 Services are delivered in a family home or facility with five or fewer Individuals receiving MHS 34 Services. The purpose of MHS 34 Services is to maintain the Individual at his or her maximum level of functioning or to improve the Individual's skills to the extent that he or she may live more independently.

Integrated setting was recently explained in a publication by the Department of Justice[1], dated June 22, 2011, as follows:

> "In the years since the Supreme Court's decision in *Olmstead v. L.C.*, 527 U.S. 581 (1999), the goal of the integration mandate in title II of the Americans with Disabilities Act [is] to provide individuals with disabilities opportunities to live their lives like individuals without disabilities."
>
> "By contrast, segregated settings often have qualities of an institutional nature. Segregated settings include, but are not limited to: (1) congregate settings populated exclusively or primarily with individuals with disabilities; (2) congregate settings characterized by regimentation in daily activities, lack of privacy or autonomy, policies limiting visitors, or limits on individuals' ability to engage freely in community activities and to manage their own activities of daily living; or (3) settings that provide for daytime activities primarily with other individuals with disabilities."

The expectation for individuals living in Adult Foster Care Services is to stabilize and transition to a non-licensed, integrated setting. Perpetual living at this level of care is not warranted and can only continue with the ongoing approval by OHA's Independent Qualified Agent (IQA) in determining this specific Level of Care (LOC).

All stays in Adult Foster Care Services shall include activities to integrate the individual into the community based on individual goals and desires, and should not be limited to foster home group activities.

[1] https://www.ada.gov/olmstead/q&a_olmstead.htm

MHS 34 Services include, but are not limited to, the following:

(1) Crisis stabilization services such as accessing psychiatric, medical, or qualified professional intervention to protect the health and safety of the individual and others;

(2) Timely, appropriate access to crisis intervention to prevent or reduce acute, emotional distress, which might necessitate psychiatric hospitalization;

(3) Management of personal money and expenses;

(4) Supervision of daily living activities and life skills, such as training in nutritional wellness, personal hygiene, clothing care and grooming, communication with social skills, health care, household management, and using community resources to support increasing independence and preparation for living in the most integrated living environment;

(5) Provision of care including assuming the responsibility for the safety and well-being of the individual;

(6) Administration and supervision of prescribed and non-prescribed medication;

(7) Provision of or arrangement for routine medical and emergency transportation;

(8) Management of aggressive or self-destructive behavior;

(9) Management of a diet, prescribed by a physician, requiring extra effort or expense in preparation of food; and .

(10) Management of physical or health problems including, but not limited to, seizures, incontinency, diabetes, and pain management.

b. **Performance Requirements**

(1) Providers of Foster Care MHS 34 Services funded through this Agreement shall comply with OAR 309-040-0300 through 309-040-0455, as such rules may be revised from time to time.

(2) Prior to commencement of Foster Care MHS 34 Services, County shall develop and submit to OHA, for OHA's review and approval, a personal care plan for the Individual. After commencement of Foster Care MHS 34 Services, County shall require that the Provider of the MHS 34 Services delivers the Services to the Individual in accordance with the Individual's personal care plan. County shall complete a new personal care plan at least annually for each Individual receiving MHS 34 Services funded through this Agreement and revise as necessary.

(3) County shall assist OHA's function of licensing and certifying homes providing Foster Care MHS 34 Services funded through this Agreement by performing the following tasks within the timelines required by OAR 309-040-0300 through 309-040-0455, as such rules may be revised from time to time:

(a) For new licenses and certifications: County shall assist with inspection of the homes, and completion and submission to OHA of the following, as prescribed by OHA:

i. Foster Home License or Certification Application;

ii. Foster Home Inspection Form;

iii. Criminal History Check;

iv. A letter of support in the form and substance attached as Attachment #1, and

v. Any other information necessary for licensing or certifying the residences.

(b) For renewal of existing licenses and certifications: County shall assist OHA with the completion and submission to OHA of a letter of support in the form and substance attached as Attachment #1, and with inspection of the homes and completion and submission to OHA of the Foster Home License/Certification Evaluation Forms; and

(c) County shall assist currently-licensed and potential new foster homes providing MHS 34 Services to meet statutory requirements for training and testing by:

i. Maintaining and distributing copies of OHA's "Basic Training Course and Self-Study Manual" and associated video tapes; and

ii. Making test site(s) available, administering tests provided by OHA, and mailing completed tests promptly to OHA for scoring.

OHA will make the final determination on issuance and renewal of licenses and certifications, based on information submitted by County as required above.

c. Reporting Requirements

See Exhibit #, 10.

d. Financial Assistance Calculation, Disbursement, and Agreement Settlement Procedures

See Exhibit D, Payment, Settlement, and Confirmation Requirements.

Use Payment and Settlement language.

In addition:

County understands and agrees that funding under Part A or Part C may be reduced by Agreement amendment to the extent County's billings under MMIS for Part B payments exceed the allocated total aggregated budget as set for in Exhibit C, "Financial Assistance Award;"

ATTACHMENT #1

Health Systems Division
500 Summer Street NE E-86
Salem, OR 97301

Dear HSD Licensing and Certification Unit Manager,

Pursuant to OAR 309-040-0315 (3)(e), I am submitting this letter of support on behalf of [name of CMHP], an authorized designee of the Local Mental Health Authority in [County].

At this time, [name of CMHP] is in support of the operation of [name of AFH] AFH located at [full address of AFH] under the following conditions:

- The provider maintains substantial compliance with all regulations that govern the licensure and safe operation of AFHs.
- The provider ensures the delivery at all times adequate room and board, food, safety and sanitation oversight, compliance with building and maintenance requirements, supervision, and care to vulnerable adults with mental, emotional, or behavioral disorders who reside at the AFH by qualified and approved providers, resident managers, staff, and volunteers.
- The provider timely submits incident reports to the CMHP in accordance with applicable ORS' and OARs.
- The provider complies with any additional requirements or conditions set forth by the Health Systems Division, Oregon Health Authority.

[name of CMHP] will immediately notify HSD when it changes its level of support for the continued operation of or adjusted placement referral decisions associated with [name of AFH] AFH.

[name of CMHP] will immediately notify HSD in writing if CMHP staff become aware of or observe any violations to regulations that govern the health, safety, and welfare of residents who reside at the home.

[name of CMHP] will provide a detailed written summary to HSD (and to the Office of Training, Investigations, and Safety, *formerly OAAPI*) if CMHP staff become aware of or observe any medication errors, inadequate or unsafe physical conditions of the home, unauthorized persons living or sleeping in the home, failure by the AFH provider to timely submit incident reports, suspected abuse or neglect to residents, crimes committed on the property, or in any other situation that jeopardizes the health, safety, and welfare of vulnerable adults who live in and receive services in the home.

Name of the LMHA representative or designee who is signing this letter of support: [name]

Full title of the LMHA representative or designee who is signing this letter of support: [title]

Email of the LMHA representative or designee who is signing this letter of support: [email]

_____ _____

Signature of the CMHP Director or designee Date of signature

34. Service Name: **OLDER OR DISABLED ADULT MENTAL HEALTH SERVICES**

Service ID Code: **MHS 35**

a. Service Description

Older or Disabled Adult Mental Health Services (MHS 35 Services) are:

(1) If Specialized Service requirement MHS 35A applies, specialized geriatric mental health Services delivered to older or disabled adults with mental illness, as such Services are further described in the Specialized Service requirement MHS 35A; or

(2) If Specialized Service requirement MHS 35B applies, residential Services delivered to older or disabled Individuals with serious and persistent mental illness, as such Services are further described in the Specialized Service requirement MHS 35B.

b. Performance Requirements

(1) Funds awarded for MHS 35 Services on lines in Exhibit C, "Financial Assistance Award," containing "35A" in column "Part IV" may only be expended on MHS 35 Services as described in the Specialized Service requirement MHS 35A.

(2) Funds awarded for MHS 35 Services on lines in Exhibit C, "Financial Assistance Award," containing "35B" in column "Part IV" may only be expended on MHS 35 Services as described in the Specialized Service requirement MHS 35B.

c. Reporting Requirements

See Exhibit E, 10.

d. Special Reporting Requirements

County shall prepare and electronically submit, to amhcontract.administrator@state.or.us, written quarterly summary financial and program narrative reports on the delivery of Older or Disabled Adult Mental Health Services, no later than 45 calendar days following the end of each subject quarter for which financial assistance is awarded through this Agreement, that are subject to Specialized Service requirements 35A and 35B. Reports must be prepared using forms and procedures prescribed by OHA. Forms are located at http://www.oregon.gov/OHA/HSD/AMH/Pages/Reporting-Requirements.aspx.

e. Financial Assistance Calculation, Disbursement, and Confirmation of Performance and Reporting Procedures

See Exhibit D, Payment, Settlement, and Confirmation Requirements.

Use Payment and Confirmation language.

In addition:

Upon amendment to the Financial Assistance Award, OHA shall adjust monthly allotments as necessary to reflect changes in the funds shown for Specialized Service requirement MHS 35A Services and Specialized Service requirement MHS 35B Services provided under that line of the Financial Assistance Award.

35. **Service Name:** **PRE-ADMISSION SCREENING AND RESIDENT REVIEW SERVICES (PASRR)**

Service ID Code: **MHS 36**

a. **Service Description**

(1) Pre-admission Screening and Resident Review Services (MHS 36 Services) are evaluation services delivered to Individuals who are entering a nursing facility where a PASRR level I screen has indicated that they have a serious and persistent mental illness (SPMI), regardless of insurance type or lack of health insurance, or are residing in a nursing home. Eligible populations served are: Medicaid, those uninsured, underinsured, or have exhausted Medicaid Services, Citizen/Alien-Waived Emergent Medical, Medicare, Private Insurance, or Private Pay.

(a) Referred for placement in Medicaid-certified long-term care nursing facilities if they are exhibiting symptoms of a serious persistent mental illness; or

(b) Residing in Medicaid-certified long-term care nursing facilities and experiencing a significant change in mental health status.

(2) Pre-admission Screening and Resident Review Services must determine if:

(a) Individuals have a serious and persistent mental illness, as defined in OAR 309-032-0860(22); and

(b) If those determined to have a serious and persistent mental illness are appropriately placed in a nursing facility or need inpatient psychiatric hospitalization.

b. **Performance Requirements**

(1) County shall comply with the Nursing Home Reform Act, under the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987), as amended by OBRA 1990, including but not limited to 42 U.S.C. 1396r(e)(7) and OAR 411-070-0043 through 411-070-0045, as such laws and rules may be revised from time to time. County shall maintain a Certificate of Approval in accordance with OAR 309-008-0100 through OAR 309-008-1600, as such rules may be revised from time to time.

(2) County shall require that all Individuals referred for MHS 36 Services by licensed nursing facilities receive MHS 36 Services review and evaluation.

(3) All MHS 36 Services paid for through this Agreement must be delivered by a Qualified Mental Health Professional (as defined in OAR 309-039-0510 (10)) or a Licensed Medical Practitioner (as defined in OAR 309-019-0105(61)).

c. **Reporting Requirements**

See Exhibit E, 10.

d. **Special Reporting Requirements**

County shall prepare and electronically submit, to amhcontract.administrator@state.or.us, written forms HSD 0438 and HSD 0440, no later than 21 calendar days following each review for which financial assistance is awarded through this Agreement. Reports must be prepared using forms and procedures prescribed by OHA. Forms are located at http://www.oregon.gov/OHA/HSD/AMH/Pages/Reporting-Requirements.aspx.

e. **Financial Assistance Calculation, Disbursement, and Confirmation of Performance and Reporting Procedures**

See Exhibit D, Payment, Settlement, and Confirmation Requirements.

Use Payment and Confirmation language.

In addition:

County understands and agrees that funding under Part C may be reduced by Agreement amendment to the extent County's billings under MMIS for Part B payments exceed the allocated total aggregated budget as set for in Exhibit C, "Financial Assistance Award".

36. **Service Name:** **START-UP**

Service ID Code: **MHS 37**

a. **Service Description**

The funds awarded for MHS 37 – Start-Up must be used for Start-Up activities as described in a special condition in Exhibit C, "Financial Assistance Award," and Exhibit K, "Start-Up Procedures." For purposes of this special project description, Start-Up activities are activities necessary to begin, expand, or improve mental health services. These expenses are distinct from routine operating expenses incurred in the course of providing ongoing services. Notwithstanding the description of the Start-Up activities in a special condition, funds awarded for MHS 37 may not be used for real property improvements of $10,000 and above. When OHA funds in the amount of $10,000 and above are to be used for purchase or renovation of real property, County shall contact the Housing Development Unit of OHA and follow the procedures as prescribed by that unit.

MHS 37 funds are typically disbursed prior to initiation of services and are used to cover approved, allowable Start-Up expenditures, as described in Exhibit J, that will be needed to provide the services planned and delivered at the specified site(s).

b. **Performance Requirements**

The funds awarded for MHS 37 must be expended only in accordance with Exhibit K, "Start-Up Procedures," which is incorporated herein by this reference.

c. **Special Reporting Requirements**

Using the OHA prescribed "Start-Up Request & Expenditure Form," the County shall prepare and electronically submit, to amhcontract.administrator@state.or.us, a request for disbursement of allowable Start-Up funds as identified in a special condition in a particular line of Exhibit C, "Financial Assistance Award." The reports must be prepared in accordance with forms prescribed by OHA and the procedures described in Exhibit K, "Start-Up Procedures." Forms are located at http://www.oregon.gov/OHA/HSD/AMH/Pages/Reporting-Requirements.aspx.

d. **Financial Assistance Calculation, Disbursement, and Agreement Settlement Procedures**

See Exhibit D, Payment, Settlement, and Confirmation Requirements.

Use Payment and Settlement language

37. **Service Name:** **SUPPORTED EMPLOYMENT SERVICES**
Service ID Code: **MHS 38**

a. **Service Description**

(1) Provide Individual Placement and Support (IPS) Supported Employment Services (MHS 38 Services) consistent with the Dartmouth IPS Supported Employment Fidelity Model. The IPS Fidelity Manual, published by Dartmouth Psychiatric Research Center, incorporated by reference herein, can be found in the IPS Employment Center's Document Library, at: https://ipsworks.org/index.php/library/, or at the following link: https://ipsworks.org/wp-content/uploads/2017/08/ips-fidelity-manual-3rd-edition_2-4-16.pdf.

(2) **Definitions:**

(a) **Competitive Integrated Employment** means full-time or part time work: at minimum wage or higher, at a rate that is not less than the customary rate paid by the employer for the same or similar work performed by other employees who are not individuals with disabilities, and who are similarly situated in similar occupations by the same employer and who have similar training, experience, and skill; with eligibility for the level of benefits provided to other employees; at a location where the employee interacts with other persons who are not individuals with disabilities (not including supervisory personnel or individuals who are providing services to such employee) to the same extent that individuals who are not individuals with disabilities and who are in comparable positions interact with other persons; and as appropriate, presents opportunities for advancement that are similar to those for other employees who are not individuals with disabilities and who have similar positions.

(b) **Division Approved Reviewer** means the Oregon Supported Employment Center of Excellence (OSECE). OSECE is OHA's contracted entity responsible for conducting Supported Employment fidelity reviews, training, and technical assistance to support new and existing Supported Employment Programs statewide.

(c) **Supported Employment Services** are individualized Services that assist Individuals to obtain and maintain integrated, paid, competitive employment. Supported Employment Services are provided in a manner that seeks to allow Individuals to work the maximum number of hours consistent with their preferences, interests, and abilities and are individually planned, based on person-centered planning principles and evidence-based practices.

b. Performance Requirements

County shall provide MHS 38 Services in a manner that is consistent with fidelity standards established in OAR 309-019-00270 through 309-019-0295 and is consistent with County's Local Plan as per ORS 430.630. If County lacks qualified Providers to deliver MHS 38 Services, County shall implement a plan, in consultation with their respective CCO and OHA, to develop a qualified Provider network for Individuals to access MHS 38 Services. MHS 38 Services must be provided by Providers meeting Supported Employment fidelity scale standards.

c. Reporting Requirements

See Exhibit E, 10.

d. Special Reporting Requirements

County shall prepare and electronically submit, to amhcontract.administrator@dhsoha.state.or.us, written quarterly summary reports on the delivery of MHS 38 Services no later than 45 calendar days following the end of each subject quarter for which financial assistance is awarded through this Agreement. Reports must be prepared using forms and procedures prescribed by OHA. Forms are located at http://www.oregon.gov/OHA/HSD/AMH/Pages/Reporting-Requirements.aspx

(a) A Provider delivering MHS 38 Services with funds provided through this Agreement may not use funds to deliver covered Services to any individual known to be enrolled in the Oregon Health Plan at the time Services are delivered.

(b) Quarterly reports shall include, but are not limited to:

i. Individuals with Serious and Persistent Mental Illness (SPMI) who receive MHS 38 Services and are employed in Competitive Integrated Employment, as defined above; and

ii. Individuals with SPMI who no longer receive MHS 38 Services and are employed in competitive integrated employment without currently receiving supportive services from a supported employment specialist; and

iii. Individuals with SPMI who received MHS 38 Services as part of an Assertive Community Treatment (ACT) Program.

e. Financial Assistance Calculation, Disbursement, and Confirmation of Performance and Reporting Requirements

See Exhibit D, Payment, Settlement, and Confirmation Requirements.
Use Payment and Confirmation language.

38. Service Name: **PROJECTS FOR ASSISTANCE IN TRANSITION FROM HOMELESSNESS (PATH) SERVICES**

Service ID Code: **MHS 39**

a. Service Description

The goal of the Projects for Assistance in Transition from Homelessness (PATH) Services program is to reduce or eliminate homelessness for Individuals with Serious Mental Illness (SMI), as defined in OAR 309-036-0105(11), and co-occurring Substance Use Disorders (SUD) who experience homelessness or are at imminent risk of becoming homeless. PATH funds are used to provide a menu of allowable Services, prioritizing street outreach, case management, and Services which are not supported by mainstream Mental Health programs. Through its Services, PATH links a vulnerable population who experience persistent and pervasive health disparities to mainstream and other supportive Services. Collectively these efforts help homeless Individuals with SMI secure safe and stable housing, improve their health, and live a self-directed, purposeful life.

Eligible Services, not otherwise covered by another resource, are as follows:

(1) Outreach services;

(2) Screening and diagnostic treatment services;

(3) Habilitation and rehabilitation services;

(4) Community mental health services;

(5) Substance use disorder treatment services;

(6) Staff training, including the training of individuals who work in shelters, mental health clinics, substance abuse programs, and other sites where Individuals who are homeless require Services;

(7) Case management services, including:

(a) Preparing a plan for the provision of community mental health and other supportive services to the eligible Individual and reviewing such plan not less than once every three months;

(b) Providing assistance in obtaining and coordinating social and maintenance services for eligible Individuals, including services relating to daily living activities, personal financial planning, transportation services, habilitation and rehabilitation services, prevocational and vocational services, and housing services;

(c) Providing assistance to eligible Individuals in obtaining income support services, including housing assistance, Supplemental Nutrition Assistance Program (SNAP) benefits, and supplemental securing income benefits;

(d) Referring eligible Individuals for such other services as may be appropriate; and

(e) Providing representative payee services in accordance with Section 1631(a)(2) of the Social Security Act if the eligible Individual is receiving aid under title XVI of such Act and if the representative payee applicant is designated by the Secretary of the Social Security Administration to provide such services.

(8) Supportive and supervisory services in residential settings;

(9) Referrals for primary health services, job training, educational services, and relevant housing services; and

(10) No more than 20% of PATH funds allocated through MHS 39 shall be expended for housing services as specified in 42 U.S.C. § 290cc-22(b)(10), which are:

(a) Minor renovation, expansion, and repair of housing;

(b) Planning of housing;

(c) Technical assistance in applying for housing assistance;

(d) Improving the coordination of housing services;

(e) Security deposits;

(f) Costs associated with matching eligible homeless Individuals with appropriate housing situations; and

(g) One-time rental payments to prevent eviction.

In order to proactively and comprehensively address the spectrum of Service needs for Individuals who experience chronic homelessness, OHA strongly encourages recipients of MHS 39 funds to use PATH funds to prioritize provision of street outreach, coupled with case management, to the most vulnerable adults who are literally and chronically homeless.

b. **Performance Requirements**

Providers of MHS 39 Services funded through this Agreement shall comply with OAR 309-032-0301 through 309-032-0351, as such rules may be revised from time to time.

Services provided must be eligible services in accordance with 42 U.S.C. § 290cc-22(b).

Providers of MHS 39 Services funded through this Agreement shall:

(1) Use third party and other revenue realized from provision of Services to the extent possible;

(2) Implement policies and procedures to prioritize use of other available funding sources for PATH Services;

(3) Assist PATH-eligible Individuals in applying for benefits for which they may be eligible for or entitled to, including but not limited to:

(a) Social Security Insurance (SSI)/Social Security Disability Insurance (SSDI) or other financial assistance;

(b) Medicaid or Medicare;

(c) Veterans Administration Benefits; and

(d) SNAP.

(4) Assist OHA, upon request, in the development of an annual application requesting continued funding for MHS 39 Services, including the development of a budget and an intended use plan for PATH funds consistent with federal requirements in accordance with 42 U.S.C. § 290cc-21; and

(5) Provide, at a minimum, the following:

(a) At least 58% of PATH-eligible Individuals contacted through outreach must be enrolled in PATH Services;

(b) At least 85% of Individuals served must be PATH-eligible and not currently enrolled in community mental health services;

(c) Of the total Individuals who are PATH-enrolled, 75% must be transitioned into permanent housing unless waived in writing by the OHA Contract Administrator based on documented lack of affordable housing resources in the PATH Provider's identified service area;

(d) Of the total Individuals who are PATH-enrolled, 100% must be engaged in community mental health services;

(e) Active participation in the local Continuum of Care;

(f) Attendance at semi-annual PATH Provider meetings;

(g) Attendance at PATH Technical Assistance trainings as requested by OHA;

(h) Development of an annual PATH intended use plan including a line item budget and budget narrative using forms and templates provided by OHA;

(i) Participation in annual PATH program site reviews conducted by OHA; and

(j) Participation in federal site reviews as needed or requested by OHA.

(6) Service Providers who are recipients of MHS 39 funds must match directly or through donations from public or private entities, non-federal contributions toward such costs in an amount that is not less than $1 for each $3 of federal PATH funds allocated through MHS 39.

(a) Non-federal contributions required may be in cash or in-kind, fairly evaluated, including plant, equipment, or services.

(b) Funding provided by the federal government, or services assisted or subsidized to any significant extent by the federal government, shall not be included in non-federal contributions.

c. **Reporting Requirements**

See Exhibit E, 10.

d. **Special Reporting Requirements**

County shall prepare and electronically submit, to amhcontract.administrator@state.or.us, written quarterly and yearly reports on the delivery of PATH Services, no later than 45 calendar days after the end of each subject quarter or year for which financial assistance is awarded through this Agreement. Reports must be prepared using forms and procedures prescribed by OHA. Forms are located at http://www.oregon.gov/OHA/HSD/AMH/Pages/Reporting-Requirements.aspx.

Each report shall provide the following information:

(1) All Individuals receiving MHS 39 Services provided through this Agreement shall be enrolled and that Individual's record maintained in the Homeless Management Information Systems (HMIS).

(2) Quarterly written reports documenting PATH eligible expenditures shall be electronically submitted to amhcontract.adminiatrator@state.or.us.

Quarterly and annual reports documenting actual utilization and demographic data submitted through the PATH Data Exchange at https://www.pathpdx.org.

e. **Financial Assistance Calculation, Disbursement, and Confirmation of Performance and Reporting Requirements Procedures**

See Exhibit D, Payment, Settlement, and Confirmation Requirements

Use Payment and Confirmation language.

2021 INTERGOVERNMENTAL AGREEMENT
FOR THE FINANCING OF COMMUNITY MENTAL HEALTH, ADDICTION TREATMENT, RECOVERY, & PREVENTION, AND PROBLEM GAMBLING SERVICES

EXHIBIT B-2
SPECIALIZED SERVICE REQUIREMENTS

Not all Services described in Exhibit B-2 may be covered in whole or in part with financial assistance pursuant to Exhibit C, "Financial Assistance Award," of this Agreement. Only Services in which costs are covered in whole or in part with financial assistance pursuant to Exhibit C, "Financial Assistance Award," as amended from time to time, are subject to this Agreement.

1. Service Name: **PEER DELIVERED SERVICES (PDS)**

Service ID Code: **MHS 16**

Specialized Service: **VETERANS**

Exhibit B-2 Code: 16A

a. **Service Description** (exceeding Section 1, MHS 16)

Contractor shall:

(1) Hire, train, and supervise Peer Support Specialists (PSS) or Peer Wellness Specialists (PWS) with significant prior or current military experience;

(2) Require that PSS or PWS acquire and maintain certification with the Oregon Health Authority, Traditional Health Worker registry, including those who identify as military veterans with current behavioral health needs;

(3) Provide PDS in a culturally competent manner as defined in OAR 410-180-0300 through 410-180-0380 to Individuals who identify as military veterans with behavioral health needs. Activities may include, but are not limited to:

(a) 1:1 peer support;

(b) Systems navigation;

(c) Facilitation of support and education groups;

(d) Outreach; and

(e) Community education.

(4) Provide program participants with funds or material supports needed to eliminate barriers to accessing health care services which will improve the veteran's behavioral health, support treatment plans, or support the veteran's recovery, or community engagement; and

(5) Engage and serve a minimum of 25 veterans annually.

b. **Performance Requirements** (exceeding Section 2, MHS 16)

None

c. **Special Reporting Requirements** (exceeding Section 3, MHS 16)

Prepare and electronically submit to amhcontract.administrator@state.or.us quarterly reports no later than 45 calendar days following the end of each subject quarter during the period for which financial assistance is awarded through this Agreement. Reports must be prepared using forms and procedures prescribed by OHA. Forms are located at http://www.oregon.gov/OHA/HSD/AMH/Pages/Reporting-Requirements.aspx.

The following information shall be provided for each report:

(1) Number of veterans served annually on a regular basis as shown by being enrolled in peer services, and making use of peer supports on a weekly basis;

(2) Number of veterans offered the pre and post survey supplied by OHA;

(3) Number of veterans completing the pre and post survey;

(4) Survey responses for all completed surveys; and

(5) Narrative description of program progress, successes, and barriers.

The following is an optional item to report:

(a) Recommendations for programs in the future which may seek to build on and scale this pilot model.

(4) Financial Assistance Calculation, Disbursement, and Confirmation of Performance and Reporting Requirements Procedures (exceeding Section 4, MHS 16)

None

2. Service Name: **NON-RESIDENTIAL MENTAL HEALTH SERVICES**

FOR YOUTH & YOUNG ADULTS IN TRANSISTION

Service ID Code: **MHS 26**

Specialized Service: **EARLY ASSESSMENT AND SUPPORT ALLIANCE (EASA)**

Exhibit B-2 Code: **26A**

a. **Service Description** (exceeding Section 1, MHS 26)

Early Assessment and Support Alliance (EASA) is a transitional, coordinated specialty care program, serving young Individuals experiencing symptoms consistent with a diagnosable psychotic disorder or at clinical high risk for such, for approximately 2 years.

Services are described in the EASA Practice Guideline (Melton, R.P., Penkin, A., Hayden-Lewis, K., Blea, P., Sisko, R., & Sale, T. (2013), incorporated by reference herein.

(1) **Definitions:**

(a) **Multi-Family Groups** means multi-family groups are a preferred method of treatment for most Individuals and their families/support system (McFarlane, 2002). Where Multi-Family Groups are not available, single family groups can be offered following the same format. Fidelity to Multi-Family Groups standards in each of the key stages is critical: joining sessions, family workshops, and carefully structured initial and ongoing problem solving sessions.

(b) **Participatory Decision Making** means Individuals and family/primary support system involved in service planning, delivery, monitoring, and evaluation seem to facilitate the development of ongoing services that are accessible and culturally appropriate for them and may result in more responsive treatment providers, better quality of care, and more empowered Individuals and primary family/primary support system (McGorry et al., 2010).

(c) **Psycho-education** means aiming to develop a shared and increased understanding of the illness and recovery process for both the Individual and the family/support system. Specific attention is given to cultural values and norms of an audience and broad accessibility to this information is essential (EASA Fidelity Guidelines, 2013).

(d) **Psychosis-Risk Syndrome** means Schizophrenia-related conditions frequently have a gradual onset. Neurocognitive, sensory, perceptual, and affective changes, usually accompanied by a decline in functioning, characterize the at-risk mental state. Identifying, monitoring, and providing needs-based care during a potential psychosis-risk mental state is optimal. The evidence regarding the effectiveness of specific interventions (therapy, medications, etc.) remains preliminary. It is measured by the Structured Interview for Psychosis-Risk syndrome (SIPS), performed by a skilled diagnostician certified in the tool (McGlashan, Walsh, & Woods, 2010), incorporated by reference herein.

(e) **Community Education** means a core element of early intervention services is a proactive and ongoing campaign to increase early identification and the speed and number of early referrals and reduce attitudinal barriers about schizophrenia-related conditions. This reduces the duration of untreated psychosis. Specific attention is given to cultural values and norms of an audience and broad accessibility to this information is essential (EASA Fidelity Guidelines, 2013).

(2) **Performance Requirements** (exceeding Section 2, MHS 26)

County shall provide Services to eligible Individuals as listed below, subject to the availability of funds:

(a) Eligible Population: EASA Services are to be provided to Individuals ages 12 through 27 years of age whom:

i. Have an IQ of 70 or above;

ii. Have not had a diagnosable psychotic disorder other than psychosis-risk syndrome, identified by the Structured Interview for Psychosis Risk Syndrome (SIPS) or other C4E approved formal assessment, for a period longer than 12 months; and

iii. Have psychotic symptoms not known to be caused by the temporary effects of substance intoxication, major depression, or attributable to a known medical condition.

(b) Access to EASA across all referral sources: emergency departments, hospitals, community partners, schools, and families, regardless of ability to pay. Upon referral, contact shall be made by EASA staff with the Individual (and family) within 24-48 hours in a location that best suits the Individual. Individuals are enrolled in EASA once they are determined to have met the eligibility criteria and agree they are comfortable with the program;

(c) Services intended to be a transitional coordinated specialty care service, designed to last an average of 2 years. An Individual's Services can be flexible with the timing of the transition, based on the needs of the Individual, their family, and the Individual's progress and goals;

(d) Services rendered based on the needs of the Individual and their family as frequently as needed to optimize the EASA program's support and impact. EASA teams should provide access to crisis services for the EASA Individual, family, and primary supports.

(e) Provide Services as described in the EASA Practice Guidelines (Melton, R.P., Penkin, A., Hayden-Lewis, K., Blea, P., Sisko, R., & Sale, T. (2013).

(f) Provide technologically-based support to EASA participants that include, but are not limited to, text messaging, email, and telemedicine in order to communicate and facilitate Services.

(g) The EASA team works with people in five phases: Assessment and stabilization, adaptation, consolidation, transition, and post-graduation.

i. Phase 1 (up to 6 months): Assessment and stabilization: Outreach, engagement, assessment, initiation of medical treatment (including psychosis and alcohol/drug dependency), identification of strengths,

resources, needs, and goals, start of multi-family groups, stabilization of current situation.

ii. Phase 2 (approximately 6 months): Adaptation: More extensive education to the individual and family/primary support system, address adaptation issues, refine/test the relapse plan, move forward on living and/or vocational goals, identify accommodations as needed at work or school, identify and develop stable long-term economic and social support, provide opportunities for peer involvement, physical fitness, etc.

iii. Phase 3 (approximately 6 months): Consolidation: Continue multi-family group, vocation support and individual treatment, work toward personal goals, develop a relapse prevention and long-term plan.

iv. Phase 4 (approximately 6 months): Transition: Maintain contact with EASA Team, continue multi-family group, participate in individual and group opportunities, establish ongoing treatment relationship and recovery plan.

v. Phase 5: Post-graduation: Continue multi-family group (in some situations), continue with ongoing providers, invitation to participate in events and mentoring, EASA planning/development activities, and periodic check-ins and problem solving as needed.

(h) Within and in addition to the phases described above, the following elements are part of the successful delivery of the EASA model and implementation of the EASA program:

i. Rapid access to psychiatric and counseling services;

ii. Education about causes, treatment, and management of psychosis and explanations about potential causes for the onset of symptoms;

iii. Coaching on rights regarding access to employment, school, housing, and additional resources;

iv. Single family psycho-education and multi-family groups;

v. Support for vocational education and independent living goals consistent with IPS framework;

vi. Access to licensed medical psychiatric care, health related nursing care, mental health treatment, case management, supported education and employment, peer support for young adult and family, and occupational therapy or skill development;

vii. Provision of substance use disorder treatment within the team

viii. Peer support (peers having lived experience with psychosis preferred regardless of age), participatory decision-making, and meaningful young adult engagement in program, community, and leadership activities as an EASA program component, and;

ix. Community-education.

(i) Setting(s) for Service Delivery: Determined by the needs and goals of the Individual and their circumstances.

(j) Recommended Staff and Staff Training: EASA team members include licensed medical providers (LMP's), nurses, staff trained in case management and care coordination, staff qualified to provide occupational therapy and associated skill training, mental health therapists, mental health screeners, peer support specialists, supported education and employment specialists.

(k) EASA services and supports must be provided by staff that enable the team/provider to meet or pursue fidelity standards located at http://www.easacommunity.org. If County lacks qualified providers to deliver EASA services and supports, a plan to adjust the model will be developed with the EASA Center for Excellence staff and OHA.

(l) Additional Licensing or Certification Requirements:

The assessment for EASA Services and supports must be provided by Providers that meet fidelity standards, located at http://www.easacommunity.org/PDF/Practice%20Guidelines%202013.pdf. If County lacks qualified Providers to deliver EASA Services and supports, County shall implement a plan, in consultation with OHA, to develop a qualified Provider network for Individuals to access EASA Services.

EASA-specific training requirements and opportunities are listed on the EASA Center for Excellence website: http://www.easacommunity.org.

(m) Staff working in the programs must have training in suicide prevention and intervention strategies and Trauma Informed Care and be provided with ongoing maintenance of the skills and practice associated with these approaches.

(3) **Special Reporting Requirements** (exceeding Section 4, MHS 26)

Forms are located at http://www.oregon.gov/OHA/HSD/AMH/Pages/Reporting-Requirements.aspx.
Counties providing EASA Services shall submit data quarterly, directly into the Oregon Health & Science University (OHSU) EASA RedCap Data System. Instructions for data entry into RedCap are located at http://www.easacommunity.org/resources-for-professionals.php and individual provider entry is located at https://octri.ohsu.edu/redcap/. Quarterly data shall be submitted no later than 45 calendar days following the end of each subject quarter for which financial assistance is awarded through this Agreement.

Data collected through RedCap will reflect outreach, referral, intake and outcome-based measures. The outcome measures will be determined based on fidelity guidelines as stated above and best practices for First Episode of Psychosis treatment.

(4) **Financial Assistance Calculation, Disbursement, and Agreement Settlement Procedures** (exceeding Section 5, MHS 26)

None.

3. Service Name: **RESIDENTIAL TREATMENT SERVICES**

Service ID Code: **MHS 28**

Specialized Service: **SECURE RESIDENTIAL TREATMENT FACILITY**

Exhibit B-2 Code: **28A**

a. **Service Description and Performance Requirements** (exceeding Exhibit B-1, MHS 28)

(1) Funds awarded for MHS 28 Services that are identified in Exhibit C, "Financial Assistance Award," as subject to this Specialized Service Requirement, may only be expended on MHS 28 Services that are delivered in Secure Residential Treatment Facilities (SRTF) (as defined in OAR 309-035-0105(60)) to Individuals discharged from state psychiatric hospitals or local acute psychiatric programs who have behaviors that are eminently harmful to themselves or others. In addition to the Services otherwise described in the MHS 28 Service Description, MHS 28 Services delivered with funds provided through this Agreement and subject to this Specialized Service Requirement include the following:

(a) A Class 1 facility (as described in OAR 309-033-0520 (2)) is approved to:
i. Be locked to prevent a person from leaving the facility;
ii. Use seclusion and restraint; and
iii. Involuntarily administer psychiatric medication.

(b) A Class 2 facility (as described in OAR 309-033-0520 (3)) is approved to be locked to prevent a person from leaving the facility.

(2) Providers of MHS 28 Services delivered with funds provided through this Agreement that are subject to this Specialized Service Requirement shall:

(a) Comply with OAR 309-035-0100 through 309-035-0190, as such rules may be revised from time to time;

(b) Deliver the Services in a facility that is residential in nature and as homelike as possible but whose buildings and grounds are locked to prevent free egress by Individuals receiving Services at the facility, in compliance with Building Code and Uniform Fire Code provisions; and

(c) Deliver the Services in a facility staffed with a combination of on-site Qualified Mental Health Professionals (as defined in OAR 309-039-0510(10)), Qualified Mental Health Associates (as defined in OAR 309-039-0510(9)), and other staff sufficient to meet the security, behavioral, recreational, and mental health needs of Individuals, as identified in their service plans, on a 24-hour basis.

b. **Reporting Requirements** (exceeding Exhibit B-1, MHS 28)

Providers of MHS 28 Services delivered with funds provided under this Agreement that are subject to this Specialized Service Requirement shall provide data related to the assessment of outcomes of such Services, as such data may be reasonably requested by OHA.

c. **Financial Assistance Calculation, Disbursement, and Agreement Settlement Procedures** (exceeding Exhibit B-1, MHS 28)

None.

4. Service Name: **OLDER OR DISABLED ADULT MENTAL HEALTH SERVICES**

Service ID Code: **MHS 35**

Specialized Service: **GERO-SPECIALIST**

Exhibit B-2 Code: **35A**

a. **Service Description** (exceeding Exhibit B-1, MHS 35)

Older or Disabled Adult Mental Health Services (MHS 35) Specialized Service requirement (MHS 35A) are mental health services delivered directly or indirectly to older or disabled adults with mental illness.

b. **Performance Requirements** (exceeding Exhibit B-1, MHS 35)

The funds awarded for MHS 35A Services may only be expended on community based direct and indirect care services for older or disabled adults with mental illness who are determined eligible. Such direct services include, but are not limited to, medication management, quarterly interagency staffing, follow-up services after treatment in local or state inpatient psychiatric hospitals, and screenings and referrals. Indirect care services include, but are not limited to, consultation, assistance working with multiple systems, case coordination, planning, supporting interagency collaboration, and education and training to agencies and caregivers who provide services that may affect older and disabled adults with mental illness.

If indirect care services, as described above, are delivered with MHS 35A funds provided through this Agreement, those services must be available to all relevant agencies and caregivers in the geographic area served by the CMHP and must be coordinated to include, but not limited to, Aging and People with Disabilities (APD), Department of Human Services (DHS)'s Aging and Disabilities Resource Connection, DHS's Adult Protective Services, CCOs, CMHPs, Acute care hospitals, Oregon State Hospital, caregivers, community partners, family members, and any other appropriate participants in client care.

All MHS 35A Services delivered with funds provided through this Agreement for direct care services must either be supervised or delivered by a Qualified Mental Health Professional, as defined in OAR 309-039-0510 (10), and in compliance with OAR 309-032-0301 through 309-032-0890 Standards for Adult Mental Health Services, as such rules may be revised from time to time. Qualified Mental Health Professionals and any designated Qualified Mental Health Associates, as defined in OAR 309-039-0510 (9), delivering such services must have a background with the older and disabled adult population or be participating in relevant training programs to acquire such knowledge.

Providers of MHS 35 Services delivered with funds provided through this Agreement that are subject to this Specialized Service requirement shall provide the following:

(1) Regular access to a psychiatrist or nurse practitioner for case and medication review for Individuals receiving direct care MHS 35 Services;

(2) Regular participation in interdisciplinary team meetings with APD staff or contractors serving Individuals receiving direct care MHS 35 Services;

(3) Discharge assistance (from in-patient psychiatric hospitals) and provide or arrange for short term follow-up services for Individuals receiving MHS 35 Services;

(4) Be available to County crisis team and DHS's Adult Protective Services for consultation on geriatric cases;

(5) Regular collaboration with APD, DHS's Aging and Disabilities Resource Connection, CMHPs, Acute care hospitals, Oregon State Hospital, living facilities, families, and others as appropriate;

(6) Indirect services shall include, but not be limited to, prevention, planning, coordination, education, and assistance with urgent placement services;

(7) Oversight, support, and inter-agency coordination and collaboration for substance abuse treatment and prevention with older and disabled adults; and

(8) Have the experience, knowledge, and authority to effect change, make recommendations, and communicate to leadership.

c. **Special Reporting Requirements** (exceeding Exhibit B-1, MHS 35)

None

d. **Financial Assistance Calculation, Disbursement, and Agreement Settlement Procedures** (exceeding Exhibit B-1, MHS 35)

None

5. Service Name: **OLDER OR DISABLED ADULT MENTAL HEALTH SERVICES**

Service ID Code: **MHS 35**

Specialized Service: **APD RESIDENTIAL**

Exhibit B-2 Code: **35B**

a. **Service Description** (exceeding Exhibit B-1, MHS 35)

Older or Disabled Adult Mental Health Services (MHS 35 Services) Specialized Service requirements (MHS 35B Services) are residential services delivered directly or indirectly to Individuals with serious and persistent mental illness.

b. **Performance Requirements** (exceeding Exhibit B-1, MHS 35)

Providers of MHS 35B Services delivered with funds provided through this Agreement shall, with respect to each Individual receiving MHS 35B Services, enter into and maintain a written agreement with DHS's Aging and People with Disabilities (APD) Program that addresses: approval of APD or its designee for the placement; the services to be provided by each entity; an annual review of treatments and services provided; and the appropriateness of the placement. In addition, an annual referral for APD eligibility is required, or earlier if there is a significant change in the Individual's physical status.

The funds awarded for MHS 35B Services may only be expended on residential services for older and disabled adults with serious and persistent mental illness, who are determined not eligible for services under the Older Americans Act of 1965 as amended, yet would benefit from residential services from APD and meet service need eligibility for Medicaid financed residential services under OAR 411-015-0000 through 411-015-0100 and are residing in a facility whose operator is licensed by APD and has contracted with APD to deliver residential services to specified Individuals.

c. **Special Reporting Requirements** (exceeding Exhibit B-1, MHS 35)

None

d. **Financial Assistance Calculation, Disbursement, and Agreement Settlement Procedures** (exceeding Exhibit B-1, MHS 35)

None.

2021 INTERGOVERNMENTAL AGREEMENT
FOR THE FINANCING OF COMMUNITY MENTAL HEALTH, ADDICTION TREATMENT, RECOVERY, & PREVENTION, AND PROBLEM GAMBLING SERVICES

EXHIBIT C
FINANCIAL ASSISTANCE AWARD

MOD#: _____

CONTRACT#: _____ CONTRACTOR: _____

INPUT CHECKED BY: _____ DATE CHECKED: _____

COLUMN HEADERS:

SE#	FUND	PROJ CODE	CPMS	PROVIDER	EFFECTIVE DATES
SLOT CHANGE / TYPE	RATE	OPERATING DOLLARS	STARTUP DOLLARS	PART ABC	PART IV
PAAF CD	BASE	CLIENT CODE	SP#		

MODIFICATION INPUT REVIEW REPORT

MOD#: A0000
CONTRACT#: 166039 CONTRACTOR: CROOK COUNTY
INPUT CHECKED BY: _____ DATE CHECKED: _____

SE#	FUND	PROJ CODE	CEMS PROVIDER	EFFECTIVE DATES	SLOT CHANGE/TYPE	RATE	OPERATING DOLLARS	STARTUP DOLLARS	PART ABC	PART IV	PART CD	BASE	CLIENT CODE	SP#
FISCAL YEAR: 2020-2021														
	GALA03		CROOK CO.											
3	998		-0-	1/1/2021 - 6/30/2021	0 /NA	$0.00	$440.00	$0.00	A	1	Y			1
				TOTAL FOR SE# 3			$440.00	$0.00						
	BASEAD		CROOK CO.											
63	STD		-0-	1/1/2021 - 6/30/2021	0 /NA	$0.00	$7,280.50	$0.00	A	1	Y			
				TOTAL FOR SE# 63			$7,280.50	$0.00						
	IDPP		CROOK CO.											
65	424		-0-	1/1/2021 - 6/30/2021	0 /NA	$0.00	$2,500.00	$0.00	C	1	Y			2
				TOTAL FOR SE# 65			$2,500.00	$0.00						
	BASEAD		CROOK CO.											
66	520		-0-	1/1/2021 - 6/30/2021	0 /NA	$0.00	$15,330.86	$0.00	A	1	Y			3
	BASEAD		CROOK CO.											
66	STD		-0-	1/1/2021 - 6/30/2021	0 /NA	$0.00	$17,948.27	$0.00	A	1	Y			3
				TOTAL FOR SE# 66			$33,279.13	$0.00						
	GAMBL		CROOK CO.											
80	450		-0-	1/1/2021 - 6/30/2021	0 /NA	$0.00	$20,000.00	$0.00	C	1	Y			4
	GAMBL		CROOK CO.											
80	998		-0-	1/1/2021 - 6/30/2021	0 /NA	$0.00	$5,000.00	$0.00	A	1	Y			
				TOTAL FOR SE# 80			$25,000.00	$0.00						
	GAMBL		CROOK CO.											
81	998		-0-	1/1/2021 - 6/30/2021	0 /NA	$0.00	$8,000.00	$0.00	A	1	Y			
				TOTAL FOR SE# 81			$8,000.00	$0.00						
				TOTAL FOR 2020-2021			$76,499.63	$0.00						
FISCAL YEAR: 2021-2022														
	GALA03		CROOK CO.											
3	998		-0-	7/1/2021 - 12/31/2021	0 /NA	$0.00	$440.00	$0.00	A	1	Y			1
				TOTAL FOR SE# 3			$440.00	$0.00						
	BASEAD		CROOK CO.											
63	STD		-0-	7/1/2021 - 12/31/2021	0 /NA	$0.00	$7,280.50	$0.00	A	1	Y			
				TOTAL FOR SE# 63			$7,280.50	$0.00						
	IDPP		CROOK CO.											

MODIFICATION INPUT REVIEW REPORT

NCD#: A0000

CONTRACT#: 166039 CONTRACTOR: CROOK COUNTY

INPUT CHECKED BY: _____ DATE CHECKED: _____

SE#	FUND	PROJ CODE	CFMS PROVIDER	EFFECTIVE DATES	SLOT CHANGE/TYPE	RATE	OPERATING DOLLARS	STARTUP DOLLARS	PART ABC	PART IV	PART CD	BASE	CLIENT CODE	SP#
FISCAL YEAR: 2021-2022														
65	424	-0-		7/1/2021 - 12/31/2021	0 /NA	$0.00	$2,500.00	$0.00	C		1	Y		2
				TOTAL FOR SE# 65			$2,500.00	$0.00						
	BASEAD	CROOK CO.												
66	520	-0-		7/1/2021 - 12/31/2021	0 /NA	$0.00	$15,330.86	$0.00	A		1	Y		3
	BASEAD	CROOK CO.												
66	STD	-0-		7/1/2021 - 12/31/2021	0 /NA	$0.00	$17,948.27	$0.00	A		1	Y		3
				TOTAL FOR SE# 66			$33,279.13	$0.00						
	GAMBL	CROOK CO.												
80	888	-0-		7/1/2021 - 12/31/2021	0 /NA	$0.00	$5,000.00	$0.00	A		1	Y		
				TOTAL FOR SE# 80			$5,000.00	$0.00						
	GAMBL	CROOK CO.												
81	888	-0-		7/1/2021 - 12/31/2021	0 /NA	$0.00	$8,000.00	$0.00	A		1	Y		
				TOTAL FOR SE# 81			$8,000.00	$0.00						
				TOTAL FOR 2021-2022			$56,499.63	$0.00						
				TOTAL FOR A0000 166039			$132,999.26	$0.00						

OREGON HEALTH AUTHORITY
Financial Assistance Award Amendment (FAAA)

CONTRACTOR: CROOK COUNTY
DATE: 02/02/2021

Contract#: 166039
REF#: 000

REASON FOR FAAA (for information only):

This Financial Assistance Agreement (FAA) is for Mental Health, Addictions Treatment, Recovery and Prevention, and Problem Gambling Services within the 2019-2021 Legislative Approved Budget (LAB) for the first six months of this Agreement and the upcoming 2021-2023 Legislative Approved Budget (LAB) for the second six months of this Agreement. This change in timeframes is due to an Oregon Health Authority (OHA) decision to change its Agreements to a calendar year basis, from January through December, rather than a biennial basis. The funding provided in the FAA was predicated on OHA's 2019-2021 LAB and as it will be proposed within the upcoming 2021-2023 budget period. The 2021-2023 LAB may include funding levels that are higher or lower than initially proposed in this Agreement. Therefore, the FAA herein may require modification, by written amendment, to this Agreement and at OHA's sole discretion, to reflect the actual funding amounts remaining in the 2019-2021 LAB and the proposed amounts in the upcoming 2021-2023 LAB. Additional ongoing approved funding changes after 12/16/2020 will be reflected in (a) subsequent amendment(s) to the FAA.

The following special condition(s) apply to funds as indicated by the special condition number in column 9. Each special condition set forth below may be qualified by a full description in the Financial Assistance Award.

A0000 1 The financial assistance subject to this special condition is awarded for system management and coordination of Services in the Addictions Services Program Area, specifically for Problem Gambling Services. If County terminates its obligation to include Problem Gambling Services under this Agreement, OHA shall have no obligation, after the termination, to pay or disburse to County the financial assistance subject to this special condition.

A0000 2 These funds are for A&D 65 IDPF Services for quarterly invoices from 1/1/2021 to 12/31/2021.

A0000 3 These funds must result in the delivery of A&D 66 Services to a minimum of 55 unduplicated individuals receiving outpatient Services and enrolled in the MOTS system on or after January 1, 2021. Up to 20% of 55 can be provided as Prevention, Education, and Outreach to non-enrolled individuals. Cases without evidence of treatment engagement in the clinical record do not count toward the service delivery requirement, except as listed above for Prevention, Education, and Outreach. Report of Prevention, Education, and Outreach must be submitted quarterly on the form located at http://www.oregon.gov/OHA/HSD/AMH/Pages/Reporting-Requirments.aspx.

CONTRACTOR: CROOK COUNTY Contract#: 166039
DATE: 02/02/2021 REF#: 000

Under delivery of Services subject to this financial assistance may result in recovery of funds at the rate of $ 1,200 per individual.

A0000 4A) The financial assistance subject to this special condition will be disbursed to County in one lump sum within 30 calendar days after the date this Agreement becomes executed. B) These funds are for A&D 80 Services to Implement Problem Gambling, Alcohol and Other Drugs Prevention Integration approved project proposal activities that integrate the commonalities of risk factors for problem gambling and substances like alcohol, tobacco, marijuana or other drugs. Provider will develop specific objective and activities or integrate project activities into existing objectives in the approved implementation plan. Provider will submit progress toward objectives and deliverables within the Problem Gambling Prevention Reporting System on a quarterly basis.

MODIFICATION INPUT REVIEW REPORT

MODE: M0267

CONTRACT#: 166039 CONTRACTOR: CROOK COUNTY

INPUT CHECKED BY: _____ DATE CHECKED: _____

SE#	FUND	PROJ CODE	CFMS PROVIDER	EFFECTIVE DATES	SLOT CHANGE/TYPE	RATE	OPERATING DOLLARS	STARTUP DOLLARS	PART ABC	PART IV	PART CD	BASE	CLIENT CODE	SE#
FISCAL YEAR: 2020-2021														
	BASE		AID & ASSIST PROJECT											
4	804		AAP	1/1/2021 - 6/30/2021	0 /NA	$0.00	$1,821.63	$0.00	A	1		Y		
				TOTAL FOR SE# 4			$1,821.63	$0.00						
	BASE		NI JAIL DIVERSION											
9	406		NIJAIL	1/1/2021 - 6/30/2021	0 /NA	$0.00	$106,666.67	$0.00	A	1		Y		
				TOTAL FOR SE# 9			$106,666.67	$0.00						
	CMHS		MH BLOCK GRANT											
20	301		BLOCK	1/1/2021 - 6/30/2021	0 /NA	$0.00	$9,997.20	$0.00	A	1		Y		
	BASE		NON-RESIDENTIAL MENT											
20	804		MHNRMH	1/1/2021 - 6/30/2021	0 /NA	$0.00	$110,828.99	$0.00	A	1		Y		
				TOTAL FOR SE# 20			$120,826.19	$0.00						
	BASE		COMMUNITY CRISIS SER											
25	406		CRISIS	1/1/2021 - 6/30/2021	0 /NA	$0.00	$15,759.00	$0.00	A	1		Y		
	BASE		COMMUNITY CRISIS SER											
25	804		CRISIS	1/1/2021 - 6/30/2021	0 /NA	$0.00	$25,000.00	$0.00	A	1		Y		
	BASE		NI CRISIS SERVICES-M											
25	806		NICRSE	1/1/2021 - 6/30/2021	0 /NA	$0.00	$91,765.79	$0.00	A	1		Y		
				TOTAL FOR SE# 25			$132,524.79	$0.00						
	BASE		PASARR FUNDS											
36	804		PASARR	1/1/2021 - 6/30/2021	0 /NA	$0.00	$750.00	$0.00	C	1		Y		1
				TOTAL FOR SE# 36			$750.00	$0.00						
				TOTAL FOR 2020-2021			$362,589.28	$0.00						
FISCAL YEAR: 2021-2022														
	BASE		AID & ASSIST PROJECT											
4	804		AAP	7/1/2021 - 12/31/2021	0 /NA	$0.00	$1,821.63	$0.00	A	1		Y		
				TOTAL FOR SE# 4			$1,821.63	$0.00						
	BASE		NI JAIL DIVERSION											
9	406		NIJAIL	7/1/2021 - 12/31/2021	0 /NA	$0.00	$106,666.67	$0.00	A	1		Y		
				TOTAL FOR SE# 9			$106,666.67	$0.00						
	CMHS		MH BLOCK GRANT											
20	301		BLOCK	7/1/2021 - 12/31/2021	0 /NA	$0.00	$9,997.20	$0.00	A	1		Y		

MODIFICATION INPUT REVIEW REPORT

MOD#: M0267
CONTRACT#: 166039 CONTRACTOR: CROOK COUNTY
INPUT CHECKED BY: _____ DATE CHECKED: _____

SE#	FUND	PROJ CODE	CFMS PROVIDER	EFFECTIVE DATES	SLOT CHANGE/TYPE	RATE	OPERATING DOLLARS	STARTUP DOLLARS	PART ABC	PART IV	PAAF CD	BASE	CLIENT CODE	SP#
FISCAL YEAR: 2021-2022														
	BASE		NON-RESIDENTIAL MENT											
20	804		MHNRMH	7/1/2021 - 12/31/2021	0 /NA	$0.00	$110,828.99	$0.00	A		1	Y		
				TOTAL FOR SE# 20			$120,826.19	$0.00						
	BASE		COMMUNITY CRISIS SER											
25	406		CRISIS	7/1/2021 - 12/31/2021	0 /NA	$0.00	$15,759.00	$0.00	A		1	Y		
	BASE		COMMUNITY CRISIS SER											
25	804		CRISIS	7/1/2021 - 12/31/2021	0 /NA	$0.00	$25,000.00	$0.00	A		1	Y		
	BASE		NI CRISIS SERVICES-M											
25	806		NICRSS	7/1/2021 - 12/31/2021	0 /NA	$0.00	$91,765.79	$0.00	A		1	Y		
				TOTAL FOR SE# 25			$132,524.79	$0.00						
	BASE		PASARR FUNDS											
36	804		PASARR	7/1/2021 - 12/31/2021	0 /NA	$0.00	$750.00	$0.00	C		1	Y		1
				TOTAL FOR SE# 36			$750.00	$0.00						
				TOTAL FOR 2021-2022			$362,589.28	$0.00						
				TOTAL FOR M0267 166039			**$725,178.56**	**$0.00**						

OREGON HEALTH AUTHORITY
Financial Assistance Award Amendment (FAAA)

CONTRACTOR: CROOK COUNTY
DATE: 02/03/2021

Contract#: 166039
REF#: 001

REASON FOR FAAA (for information only):

This Financial Assistance Agreement (FAA) is for Mental Health, Addictions Treatment, Recovery and Prevention, and Problem Gambling Services within the 2019-2021 Legislative Approved Budget (LAB) for the first six months of this Agreement and the upcoming 2021-2023 Legislative Approved Budget (LAB) for the second six months of this Agreement. This change in timeframes is due to an Oregon Health Authority (OHA) decision to change its Agreements to a calendar year basis, from January through December, rather than a biennial basis. The funding provided in the FAA was predicated on OHA's 2019-2021 LAB and as it will be proposed within the upcoming 2021-2023 budget period. The 2021-2023 LAB may include funding levels that are higher or lower than initially proposed in this Agreement. Therefore, the FAA herein may require modification, by written amendment, to this Agreement and at OHA's sole discretion, to reflect the actual funding amounts remaining in the 2019-2021 LAB and the proposed amounts in the upcoming 2021-2023 LAB. Additional ongoing approved funding changes after 12/16/2020 will be reflected in (a) subsequent amendment(s) to the FAA.

The following special condition(s) apply to funds as indicated by the special condition number in column 9. Each special condition set forth below may be qualified by a full description in the Financial Assistance Award.

M0267 1A) These funds are for MHS 36 for Non-Medicaid clients. B) For Services delivered to individuals, financial assistance awarded to County shall be disbursed to County and expended by County in accordance with and subject to the residential rate on the date of service delivery based upon the rate schedule found at www.oregon.gov/OHA/HSD/OHP/Pages/Fee-Schedule.aspx and incorporated into this Agreement by reference that is effective as of the effective date of this Agreement unless a new rate schedule is subsequently incorporated by amendment. Any expenditure by County in excess of the authorized rates as set forth www.oregon.gov/OHA/HSD/OHP/Pages/Fee-Schedule.aspx may be deemed unallowable and subject to recovery by OHA in accordance with the terms of this Agreement.

EXPLANATION OF FINANCIAL ASSISTANCE AWARD

The Financial Assistance Award set forth above and any Financial Assistance Award amendment must be read in conjunction with this explanation for purposes of understanding the rights and obligations of OHA and County reflected in the Financial Assistance Award.

1. Format and Abbreviations in Financial Assistance Award

a. Heading. The heading of the Financial Assistance Award consists of the following information:

(1) **MOD#** is the alphanumeric Modification code, assigned by the OHA HSD Contract Unit's staff member, for that specific Financial Assistance Award. A MOD# beginning with an M is a mental health modification; a MOD# beginning with an A is a substance use disorder or problem gambling modification.

(2) **CONTRACT#** is the unique identification number of the Agreement containing the Financial Assistance Award. This number is assigned by the Office of Contracts & Procurement (OC&P).

(3) **CONTRACTOR** is the County or the legal entity named in and for that specific Agreement containing the Financial Assistance Award.

(4) **Input Checked** is for OHA's internal use only.

(5) **Date Checked** is for OHA's internal use only.

b. Financial and Service Information. Each Service awarded funds is listed by Fiscal Year and then by the Service Element number. The amount of financial assistance awarded for each Service and certain other Service information is listed below the Fiscal Year and then by the Service Element number on one or more lines. Financial assistance awarded for a particular Service may not be used to cover the costs of any other Service, except as permitted under Exhibit F, "General Terms and Conditions," section 3.a, of this Agreement. The funds, as set forth on a particular line, will be disbursed in accordance with and are subject to the restrictions set forth on that particular line. The awarded funds, disbursement information and restrictions on a particular line are displayed in a columnar format as follows:

(1) **Column 1, SE#:** The Service Element number(s) identifies the Service or Service capacity, as applicable, to be delivered under the approved Service Element(s), as set forth on that particular line of the Financial Assistance Award.

(2) **Column 2, Fund:** This column identifies the fund number and description of the funding source, according to HSD's financial system, used for payments for this specific line of the Financial Assistance Award. The types of funds are as follows:

(a) 301 Mental Health Block Grant (MHBG) – Federal Funds

(b) 313 Projects for Assistance in Transition from Homelessness (PATH) - Federal Funds

(c) 401 Mental Health Marijuana Tax – Other Funds

(d) 402 Cares Act Coronavirus Relief Fund– Federal Funds

(e) 406 Tobacco Tax New Investments – Other Funds

(f) 411 Tobacco Master Settlement Account – Other Funds

(g)	420	Beer and Wine Tax (20%) – Other Funds
(h)	421	Beer and Wine Tax (40%) Treatment – Other Funds
(i)	424	Intoxicated Driver Program Fund Outpatient – Other Funds
(j)	426	Criminal Fines Assessment Prevention – Other Funds
(k)	427	Marijuana Tax (20%) – Other Funds
(l)	450	Marijuana Tax (40%) – Other Funds
(m)	550	Medication Assisted Treatment – Federal Funds
(n)	560	State Opioid Response – Federal Funds
(o)	570	State Targeted Response to Opioid Crisis – Federal Funds
(p)	520	Substance Abuse Prevention and Treatment (SAPT) Treatment – Federal Funds
(q)	708	Temporary Assistance for Needy Families (TANF) Programs – Federal Funds
(r)	804	Mental Health – General Funds
(s)	806	Mental Health New Investments – General Funds
(t)	807	Alcohol and Drug Treatment – General Funds
(u)	888	Gambling Treatment – Lottery Funds
(v)	908	Temporary Assistance for Needy Families (TANF) Programs – General Fund Match
(w)	STD	Standard Fund Splits – Uses multiple fund types by percentage.
(x)	SMI	Standard Fund Splits – Uses multiple fund types by percentage.
(y)	SDX	Standard Fund Splits – Uses multiple fund types by percentage.
(z)	SBD	Standard Fund Splits – Uses multiple fund types by percentage.
(aa)	SBT	Standard Fund Splits – Uses multiple fund types by percentage.
(bb)	DDX	Standard Fund Splits – Uses multiple fund types by percentage.

The fund numbers with source descriptions identifying General Funds or Other Funds as the funding source may actually be paid under a different fund number and source based upon actual funds available at the time of payment. **Changes to the Financial Assistance Award to move amounts from one fund source to another fund source but otherwise budget neutral will be processed as an Administrative Adjustment rather than issuing an Amendment to the Financial Assistance Award. The notice of Administrative Adjustment will be sent to the County via email to the contact person listed in Exhibit G, "Standard Terms and Conditions," Section 18., "Notice." County shall have 30 calendar days to request OHA replace the Administrative Adjustment notice with an Amendment to the Financial Assistance Award. If the County does not make such a request, the Financial Assistance Award shall be deemed amended as noted in the Administrative Adjustment and agreed to by both parties.**

(3) **Column 3, Proj Code:** This item is for OHA internal use only.

(4) **Column 4, CPMS:** This item is for OHA's internal use only.

(5) **Column 5, Provider:** This is either the Provider's name or a description for a specific Service as set forth on that particular line of the Financial Assistance Award.

(6) **Column 6, Effective Dates:** This specifies the time period during which the Service or Service capacity, as applicable, is expected to be delivered utilizing the approved Service funds as set forth on that particular line of the Financial Assistance Award. For purposes of disbursement method "A" (as described in Section (11), "Column 11, Part ABC," below), these dates also specify the time period during which the approved Service funds will be disbursed to County.

(7) **Column 7, Slot Change/Type:** This is either the number of slots or number of days of Service or Service capacity, as applicable, OHA anticipates County to deliver during the period specified and utilizing the approved Service funds set forth on that particular line of the Financial Assistance Award. The Service or Service capacity, as applicable, must be delivered in the amounts and over the course of the time period, as specified on that line of the Financial Assistance Award. This column will be blank, followed by NA if the basis of payment set forth in the applicable Service Description is not tied to actual delivery of Services or Service capacity. The Slot Change/Type is the unit of measurement associated with the Effective Dates set forth in column 6. The Slot Change/Type is expressed in three-character designations and have the following meanings:

(a) **CSD:** One CSD (or Client Service Day) is one day of Service or Service capacity, as applicable, delivered to one Individual or made available for delivery to one Individual, as applicable.

(b) **N/A:** N/A means Slot Change/type is not applicable to the particular line.

(c) **SLT:** One SLT (or Slot) is the delivery or capacity to deliver, as applicable, the Service to an Individual during the entire period specified in the corresponding line of the Financial Assistance Award.

(8) **Column 8, Rate:** This is the cost per day, per month, or per Slot Change/Type measurement for the Service or Service capacity, as applicable, to be delivered utilizing the approved Service funds, as set forth on that line of the Financial Assistance Award.

(9) **Column 9, Operating Dollars:** This is the total amount of funds awarded under this Agreement, as amended from time to time, for delivery of the Service and is OHA's maximum, not-to-exceed obligation during the time period specified on that particular line, in support of the Services described on that particular line, of the Financial Assistance Award.

(10) **Column 10, Startup Dollars:** This is the total amount of funds awarded under this Agreement, as amended from time to time, to be used only for one-time expenses, incurred in initiating, expanding, or upgrading the specified Service, or for other special one-time expenses related to the Service. Startup funds may only be spent for the purposes specified in the Special Condition(s) as listed in Column 16, "SP#." Startup funds are to be expended only in accordance with Exhibit K of this Agreement and with startup procedures within the applicable Service Elements.

(11) **Column 11, Part ABC:** This column indicates the method by which OHA disburses the funds awarded under the Agreement, as amended from time to time. The disbursement method listed in this column, as indicated by the letter A, B, or C, will usually be consistent with the disbursement method set forth in the Service Description for the particular Service Element. The characters A, B and C indicate the following disbursement methods:

(a) The letter 'A' indicates OHA will disburse the awarded funds to County in substantially equal monthly allotments during the period set forth in Column 6, "Effective Dates."

(b) The letter 'B' indicates OHA will disburse awarded funds under another agreement and are set forth in this Agreement for tracking purposes only.

(c) The letter 'C' indicates OHA will disburse the awarded funds in the manner specified in Column 16, "SP#."

If the disbursement method listed in this column is different than the method set forth in the Service Description, the disbursement method listed in this column shall control. This column only indicates the disbursement method to be used should County be entitled to receive funds awarded, which shall be determined in accordance with the basis of payment as set forth in the applicable Service Element. Any disbursements made to County in excess of the funds County is entitled to, as determined in accordance with the applicable basis of payment and through the Agreement Settlement process, will be recovered by OHA in accordance with the terms of this Agreement.

(12) **Column 12, Part IV:** This is the Specialized Service Requirement Code, if applicable, and corresponds with the Specialized Service Requirement described in Exhibit B-2. If a code appears in this column, the Service must be delivered in accordance with the Specialized Service Requirement when the Service is delivered using approved Service funds, as set forth on that line of the Financial Assistance Award.

(13) **Column 13, PAAF CD:** This column is the Plan/Amendment Approval Form (PAAF) code, which is the lookup field to title the various sections of the PAAF based on this PAAF code.

(14) **Column 14, Base:** This is the code used to indicate how the Services being provided, as set forth on that line of the Financial Assistance Award, are to be handled at the end of the respective biennium, as follows:

(a) The letter "Y" in this field indicates the Services subject to and modified by this Agreement, hereafter referred to as MOD, as set forth on that line of the Financial Assistance Award may continue into the next biennium. This will be contingent on the Services still being required, at that time and at that level, and upon OHA's funding being continued at the present funding level or higher, through the Legislatively Adopted Budget for that specific biennium.

(b) The letter "N" in this field indicates the Services being modified in this MOD, as set forth on that line of the Financial Assistance Award, are not continuing into the next biennium.

(c) The letter "M" in this field indicates the Services being modified in this MOD, as set forth on that line of the Financial Assistance Award, are "maybe" going to continue into the next biennium. This will be determined at the time OHA is preparing the next biennium's Agreements. This code is typically used for Services paid by Federal Grants.

(15) **Column 15, Client Code:** This column is used when Service funds, as set forth on that line of the Financial Assistance Award, are for a specific client. The coded client name indicates the approved Service funds may only be expended on the delivery of the specified Service to the specified Individual. If this column is blank, Service funds are not intended for any particular Individual.

(16) **Column 16, SP#:** This column is for Special Conditions, if any, that must be complied with when providing the Service using approved service funds set forth on that line of the Financial Assistance Award. For certain Services, the Special Conditions specify the rate at which financial assistance will be calculated for delivery of that Service or delivery of capacity for that Service. The Special Conditions are identified by a numeric code. A table or tables listing the Special Conditions by numeric code is included in the Financial Assistance Award.

2. **Format and Abbreviations in Financial Assistance Award Amendments.** The format and abbreviations in a Financial Assistance Award amendment are the same as those used in the initial Financial Assistance Award. If a Financial Assistance Award amendment amends the financial and service information in the Financial Assistance Award, each financial and service information line in the amendment will either amend an existing line in the financial and service information of the Financial Assistance Award or constitute a new line added to the financial and service information of the Financial Assistance Award. A financial and service information line in a Financial Assistance Award amendment (an "Amending Line") amends an existing line of the Financial Assistance Award (a "Corresponding Line") if the line in the Financial Assistance Award amendment awards funds for the same Service, specifies the same Child and Adolescent Needs and Strengths (CANS) Name (if applicable), and specifies the same SE# as an existing line (as previously amended, if at all) in the Financial Assistance Award and specifies a date range falling within the Effective Dates specified in that existing line (as previously amended, if at all). If an Amending Line has a positive number in the approved Operating Dollars column, those funds are added to the approved Operating Dollars of the Corresponding Line for the period specified in the Amending Line. If an Amending Line has a negative number in the approved Operating Dollars column, those funds are subtracted from the approved Operating Dollars of the Corresponding Line for period specified in the Amending Line. If an Amending Line has a positive number in the Slot Change/Type column, those Slots are added to the Slot Change/Type in the Corresponding Line for the period specified in the Amending Line. If an Amending Line has a negative number in the Slot Change/Type column, those Slots are subtracted from the Slot Change/Type in the Corresponding Line for the period specified in the Amending Line. All Special Conditions identified in a Corresponding Line apply to funds identified on an Amending Line (unless a Special Condition or portion thereof on an Amending Line specifies a rate). If an Amending Line contains a Special Condition or portion of a Special Condition that specifies a rate, that Special Condition or portion thereof replaces, for the period specified in the Amending Line, any Special Condition or portion thereof in the Corresponding Line that specifies a rate. If a financial and service information line in a Financial Assistance Award amendment is not an Amending Line, as described above, it is a new line added to the Financial Assistance Award.

2021 INTERGOVERNMENTAL AGREEMENT
FOR THE FINANCING OF COMMUNITY MENTAL HEALTH, ADDICTION TREATMENT, RECOVERY, & PREVENTION, AND PROBLEM GAMBLING SERVICES

EXHIBIT D
PAYMENT, SETTLEMENT, AND CONFIRMATION REQUIREMENTS

1. OHA provides funding for Services through Part A, B, or C awards. The award type is identified in Exhibit C, "Financial Assistance Award," on lines in which column "Part ABC," contains an "A" for Part A award, a "B" for Part B award, and a "C" for Part C award:

a. Funds awarded to County or Service Providers are subject to the following:

(1) OHA shall not authorize in aggregate, under this "Financial Assistance Calculation and Disbursement" section, financial assistance requested for Services in excess of the contractual Not-to-Exceed amount. "Total aggregate funding" means the total of all funding authorized in Exhibit C, "Financial Assistance Award" before reducing funding to account for client resources received by the County or Service Provider from an Individual, or from another on behalf of the Individual, in support of Individual's care and Services provided. The monthly rate will be prorated for any month in which the Individual does not receive Services for a portion of the month. Funding will be reduced (offset) by the amount of funding received by the Service Provider from the Individual, the Individual's health insurance provider, another person's health insurance provider under which Individual is also covered, or any other Third-Party Resource (TPR) in support of Individual's care and Services provided for the same Service, during the same time period or date of Service for the same Individual. County is obligated to report to OHA, by email at amhcontract.administrator@state.or.us, any TPR payments no later than 30 calendar days following receipt of payment by County or Service Provider. The following information shall be provided:

(a) OHA Contract name and number;
(b) Client name and date of birth;
(c) Service for which payment was received;
(d) Date of service covered by payment; and
(e) Amount of payment.

(2) County is not entitled to funding in combination with Medicaid funds for the same Service, during the same time period or date of Services for the same Individual;

(3) At no time will OHA pay above the Medicaid rate. Additionally, OHA will not pay above the Medicaid rate in accordance with the OHA Mental Health and Developmental Disability Services Medicaid Payment for Rehabilitative Mental Health Services Rule, posted on the HSD PASRR website located at: http://www.oregon.gov/oha/HSD/AMH/Pages/PASRR.aspx, as it may be revised from time to time.

(4) OHA is not obligated to provide funding for any Services that are not properly reported in accordance with the "Reporting Requirements" and "Special Reporting Requirements" sections of this Contract or as required in an applicable Specialized Service Requirement by the date 60 calendar days after the earlier of expiration or

termination of this Agreement, termination of OHA's obligation to provide funding for Services, or termination of County's obligation to include the Program Area in which Services fall; and

b. Part A awards:

OHA provides financial assistance for Services through Part A for non-Medicaid-eligible Services. County and Service Providers shall maintain compliance with OAR 410-172-0600 through 0860 Medicaid Payment for Behavioral Health, and OAR 943-120-0310 through 0320 Provider Enrollment Services in MHS 01, 08, 09, 10 ,12, 13, 15, 16, 20, 22, 24, 25 ,26, 27, 28, 31, 34, 36, and A&D 61, 63, 65 ,66, and 67.

(1) **Calculation of Financial Assistance**: OHA will provide financial assistance for Services provided under a particular line of Exhibit C, "Financial Assistance Award," containing an "A" in column "Part ABC," from funds identified in that line in an amount equal to that line of the Financial Assistance Award during the period specified in that line. The total of OHA funds for all Services delivered under a particular line of Exhibit C, "Financial Assistance Award" containing an "A" in column "Part ABC," shall not exceed the total of awards for Services as specified in that line of the Financial Assistance Award and are subject to the limitations described herein.

(2) **Disbursement of Financial Assistance**: Unless a different disbursement method is specified in that line of Exhibit C, "Financial Assistance Award," OHA will disburse the Part A allotments for Services provided under a particular line of the Financial Assistance Award containing an "A" in column "Part ABC," to County in substantially equal monthly allotments during the period specified in that line of the Financial Assistance Award subject to the following:

(a) OHA may, upon written request of County, adjust monthly allotments;
(b) Upon amendment to the Financial Assistance Award, OHA shall adjust monthly allotments as necessary, to reflect changes in the funds shown for Services provided under that line of the Financial Assistance Award; and,
(c) OHA may, after 30 calendar days (unless parties agree otherwise) written notice to County, reduce the monthly allotments based on under-used funding identified through MOTS and other reports in accordance with the "Reporting Requirements" and "Special Reporting Requirements" sections or applicable special conditions.

c. Part B awards:

Part B is used for any award or payment that is made outside of the State Financial Management Application (SFMA) payment system. For this Agreement, an example of that type of system is the Medicaid Management Information System (MMIS). Part B Limitation awards are not disbursed or settled under this Agreement, but are included for budgetary purposes.

(1) Part B awards are calculated and applied as follows:

(a) The provider of Services must be enrolled as a Medicaid Provider and follow the procedures for billing OHA for Medicaid Community Mental Health, or Addiction Treatment, Recovery, & Prevention, and Problem Gambling Services for Medicaid-eligible Individuals through MMIS as outlined in the Medicaid Professional Billing Instructions Manual, available on the OHA website at: http://www/oregon.gov/OHA/HSD/OHP/Pages/webportal.aspx?wp4796=1:100;

(b) OHA calculates the rates and then processes claims through OHA's MMIS. Part B Limitation is calculated, and payment is made through MMIS directly to the Service Provider on a fee-for-services (FFS) basis. The FFS rates and additional Medicaid Provider resources are available on the OHA website at: http://www.oregon.gov/oha/HSD/OHP/Pages/index.aspx; and

(c) OHA will provide notice to County in a timely manner if there is a change in rates, which shall be established by OHA's Rate Standardization Committee in its sole discretion. All Medicaid reimbursable service billings shall be in accordance with OHA HSD's Medical Assistance Program Rules as listed in OAR 410-172-0600 through 410-172-0860.

d. Part C awards:

(1) Part C awards are calculated and applied as follows:

The Part C financial assistance will be disbursed as follows: Unless a different disbursement method is specified in that line of the Exhibit C, "Financial Assistance Award," OHA will disburse the Part C funds for Services provided under a particular line of the Financial Assistance Award containing a "C" in column "Part ABC" to County per receipt and approval of a written invoice with required attachments, as specified below, in the monthly allotment during the period specified in that line of the Financial Assistance Award. Invoice and required attachments are due no later than 45 calendar days following the end of the subject month or quarter, and must be submitted to amhcontract.administrator@state.or.us with the subject line "Invoice, contract # (your contract number), contractor name." Financial assistance provided by OHA are subject to the limitations described in this Agreement.

(a) For Services to Medicaid-eligible Individuals for whom the Services provided are not covered under Medicaid but are medically appropriate, County shall attach a copy of the Plan of Care (POC) and Coordinated Care Organization (CCO) refusal of payments for the item or Service. OHA will provide funding at the Medicaid Fee Schedule rate. At no time will OHA provide funding above the Medicaid Fee Schedule rate for Services.

(b) For Services to non-Medicaid-eligible Individuals, County shall attach a copy of the bill or receipt, for the item or Service, to a combined monthly invoice, itemized by Individual. Part C funding for Psychiatric Security Review Board (PSRB) non-medically approved Services are only for the time period shown and do not carry forward into following years' allotments.

e. Start-Up awards:

(1) Calculation of Financial Assistance: OHA will provide financial assistance for A&D 60 and MHS 37 Services from funds identified in a particular line of Exhibit C, "Financial Assistance Award," in an amount equal to the amount requested on the Start-Up form submitted by County, subject to the requirements of Exhibit K, "Start-Up Procedures." The total OHA financial assistance for all A&D 60 and MHS 37 activities described herein under a particular line of the Financial Assistance Award shall not exceed the total funds awarded for A&D 60 and MHS 37 as specified in that line of the Financial Assistance Award.

(2) Disbursement of Financial Assistance:

(a) Unless a different disbursement method is specified in that line of Exhibit C, "Financial Assistance Award," OHA will disburse the Start-Up funds awarded for A&D 60 and MHS 37 in a particular line of the Financial Assistance Award after OHA's receipt, review, and approval of County's properly completed "Start-Up Request & Expenditure Report," as described in and in accordance with Exhibit L, "Start-Up Procedures."

(b) After execution of the Agreement or any amendment(s) for Start-Up disbursements, County may request an advance of funds it anticipates using in the subsequent 120 calendar days.

(f) Settlement and Confirmation of Performance Requirements:

OHA uses either Settlement or Confirmation of Performance requirements at the end of each contracting period. The specific requirement will be listed in each individual Service Description.

(1) Agreement Settlement:

(a) Agreement Settlement will be used to reconcile any discrepancies that may have occurred during the term of this Agreement between actual OHA disbursements of funds awarded for Services under a particular line of Exhibit C, "Financial Assistance Award," containing an "A" in column "Part ABC," and amounts due for such Services based on the rate set forth in the special condition identified in that line of the Financial Assistance Award. For purposes of this section, amounts due to County are determined by the actual amount of Services delivered under that line of the Financial Assistance Award, as properly reported in accordance with the "Reporting Requirements" and "Special Reporting Requirements" sections of the

Agreement or as required in an applicable Specialized Service Requirement, and subject to the terms and limitations in this Agreement.

The settlement process will not apply to funds awarded for an approved reserved service capacity payment.

(b) Agreement Settlement for Start-Up Services:

Agreement Settlement will be used to reconcile any discrepancies that may have occurred during the term of this Agreement between actual OHA disbursements of funds awarded for Start-Up and amounts due for Services based on actual allowable expenditures incurred in accordance with the Service Description and Exhibit L, "Start-Up Procedures."

County shall submit all Start-Up Request and Expenditure Reports at the level of detail prescribed by OHA. Any reports not submitted by 45 calendar days after the expiration or termination date of this Agreement, whichever is earlier, shall not be accepted nor any funds owed by OHA.

(2) Confirmation of Performance and Reporting Requirements:

County shall be required to demonstrate through the data properly reported in accordance with the "Reporting Requirements" and "Special Reporting Requirements" sections, the qualifying Services to which these Services can be attributed, how funds awarded were utilized consistent with the terms and limitations herein to meet the performance requirements of the Service Description, and that County shall be subject to the monitoring and review of performance requirements and quality measures by the OHA Contract Administrator for the Program under which these Services falls and subject to the terms and limitations in this Agreement.

2021 INTERGOVERNMENTAL AGREEMENT
FOR THE FINANCING OF COMMUNITY MENTAL HEALTH, ADDICTION TREATMENT, RECOVERY, & PREVENTION, AND PROBLEM GAMBLING SERVICES

EXHIBIT E
SPECIAL TERMS AND CONDITIONS

1. **County Expenditures on Addiction Treatment, Recovery, & Prevention Services.** In accordance with ORS 430.345 to 430.380 (the "Mental Health Alcoholism and Drug Services Account"), County shall maintain its 2019-2020 financial contribution to alcohol and other drug treatment and prevention services at an amount not less than that for fiscal year 2018-2019 Furthermore, and in accordance with the Mental Health Alcoholism and Drug Services Account, County shall maintain its 2020-2021financial contribution to alcohol and other drug treatment and prevention services at an amount not less than that for fiscal year 2019-2020 OHA may waive all or part of the financial contribution requirement in consideration of severe financial hardship or any other grounds permitted by law.

2. **Limitations on use of Financial Assistance Awarded Addiction Treatment, Recovery, & Prevention Services.** Financial assistance awarded under this Agreement for Addiction Treatment, Recovery, & Prevention Services (as reflected in the Financial Assistance Award), may not be used to:

   a. Provide inpatient hospital services;

   b. Make cash payments to intended recipients of health services;

   c. Purchase or improve land, to purchase, construct or permanently improve (other than minor remodeling) any building or other facility or to purchase major medical equipment;

   d. Satisfy any requirement for expenditure of non-federal funds as a condition for receipt of federal funds (whether the federal funds are Federal Funds under this Agreement or otherwise); or

   e. Carry out any program prohibited by section 256(b) of the Health Omnibus Programs Extension Act of 1988 (codified at 42 U.S.C. 300ee-5), which specifically prohibits funds provided under this Agreement from being used to provide Individuals with hypodermic needles or syringes so that such Individuals may use illegal drugs, unless the Surgeon General of the Public Health Service determines that a demonstration needle exchange program would be effective in reducing drug abuse.

3. County shall maintain separate fund balances for the Community Mental Health, Addiction Treatment, Recovery, & Prevention, and Problem Gambling Services.

4. **County Investigating and Reporting Allegations of Abuse for Mental Health Services.** County shall investigate and report all allegations of abuse regarding served Individuals and provide protective services to those Individuals to prevent further abuse. The investigation, reporting and protective services must be completed in compliance with ORS 430.735 through 430.765 and OAR 407-045-0120 through 407-045-0955, as such statutes and rules may be revised from time to time.

5. **Trauma Informed Services** also referred to as **Trauma Informed Care (TIC).** CMHP shall comply with OAR 309-019-0105(118) as it relates to TIC. Providing any OHA Services, CMHP will have a TIC plan and TIC will appear as a core principle in CMHP policies, mission statement, and written program and service information, in accordance with OHA Trauma Informed Care

(TIC) Policy located at https://www.oregon.gov/oha/amh/trauma-policy/Trauma%20Policy.pdf. CMHP will initiate and complete an agency self-assessment and have a quality assurance structure/process to further develop and sustain TIC.

6. **Promotion, Prevention, Early Identification and Intervention.** Within available funds, CMHP will focus on promotion, prevention and early identification and intervention of conditions that lead to behavioral and mental health conditions in the array of interventions supported by CMHP services. This focus will lead to improved outcomes and enhanced healthcare experiences for Individuals as well as reduce overall expenditures.

7. **Clinical Interventions and Support Services** provided to any Individual enrolled in the Oregon Health Plan (OHP) who is covered for these Services and for which the CCO or Medical Assistance Programs (MAP) pays for these Services are not eligible for Services. The OHP benefit package includes many of the Services provided under this Agreement. The intent is not to duplicate OHP but rather augment the package of Services.

8. **Performance Standards and Quality Measures.** County shall comply with the following:

   a. A Provider delivering Services with funds provided through this Agreement may not use funds to deliver covered Services to any Individual known to be enrolled in the Oregon Health Plan.

   b. The quality of Services supported with funds provided through this Agreement will be measured in accordance with the criteria set forth below. The criteria are applied on a countywide basis each calendar quarter (or portion thereof) during the period for which the funds are awarded. County shall develop and implement quality assurance and quality improvement processes to progressively improve, as measured by the criteria set forth below, the quality of Services provided under this Agreement. OHA may provide performance incentive funds to some or all of these standards and measures. OHA may recommend additional actions to improve quality.

      (1) **Access:** Access is measured by OHA as the percentage of county residents, as estimated by an OHA approved survey to determine treatment need, who are enrolled in Services with the exception of prevention and promotion. This measure applies to all program areas; Community Mental Health, Addiction Treatment, Recovery, and Prevention, and Problem Gambling Services.

      (2) **Treatment Service Initiation:** Treatment service initiation is measured as the percentage of Individuals served within 14 calendar days of the original assessment, also known as the index date. The index date is a start date with no Services in the prior 60 calendar days. This measure applies to all program areas; Community Mental Health, Addiction Treatment, Recovery, and Prevention, and Problem Gambling Services.

      (3) **Treatment Service Retention:** Treatment service retention is measured as the percentage of Individuals engaged in and receiving Services (excluding prevention and promotion) with funds provided through this Agreement who are actively engaged in Services for 90 calendar days or more. This measure applies to all program areas; Community Mental Health, Addiction Treatment, Recovery, & Prevention, and Problem Gambling Services.

      (4) **Reduced Use:** Reduced use is measured as the percentage of Individuals engaged in and receiving Addiction Treatment, Recovery, & Prevention Services with funds

provided through this Agreement who reduce their use of alcohol or other drugs during treatment/Services, as reported in MOTS.

(5) **Facility-Based Care Follow-Up:** Facility-based care follow-up is measured by the percentage of Individuals with a follow-up visit within 7 calendar days after hospitalization for mental illness or any facility-based Service defined as residential. This measure applies to all program areas; Community Mental Health, Addiction Treatment, Recovery, & Prevention, and Problem Gambling Services.

(6) **Hospital and Facility-Based Readmission Rates:** Hospital and facility-based readmission rates are measured as a percentage of the number of Individuals returning to the same or higher levels of care within 30 and 180 calendar days divided by the total number of discharges. This measure applies to all program areas; Community Mental Health, Addiction Treatment, Recovery, & Prevention, and Problem Gambling Services.

(7) **Parent-Child Reunification:** Parent-child reunification is measured as a percentage by dividing the number of parents reunited with a child (or multiple children) by the total number of parents served who had children in an out-of-home placement or foster care due to child welfare involvement. This measure applies to Addiction Treatment, Recovery, & Prevention Services only.

(8) **Functional Outcomes – Housing Status; Employment Status; School Performance; and Criminal Justice Involvement:** Four functional outcome measures will be monitored by OHA and reported to the County as follows:

(a) **Housing Status:** This measure will be monitored and reported when improved housing status is established as a goal of treatment and Services; or when a person is homeless or in a licensed care facility. The measure is expressed as the number of Individuals who improve housing status, as indicated by a change from homelessness or licensed facility-based care to private housing, divided by the total number of Individuals with a goal to improve housing. This measure applies to all program areas; Community Mental Health, Addiction Treatment, Recovery, & Prevention, and Problem Gambling Services.

(b) **Supported Housing:** This measure is to count integrated housing for Individuals with Serious and Persistent Mental Illness (SPMI). The measure will be calculated based on the Individuals receiving rental assistance through the Rental Assistance Program and through the identification of Supported Housing in the community.

(c) **Employment Status:** This measure will be monitored and reported when employment is a goal of treatment and Services. This measure is expressed as the number of Individuals who become employed, as indicated by a change in employment status, divided by the total number of Individuals with a goal of becoming employed. This measure applies to all program areas; Community Mental Health, Addiction Treatment, Recovery, & Prevention, and Problem Gambling Services.

(d) **School Performance:** This measure will be monitored and reported when improved school attendance is a goal of treatment and Services. The measure is expressed as the number of Individuals who improve attendance in school while in active treatment, divided by the total number of

Individuals with a goal of improved attendance. This measure applies to all program areas; Community Mental Health, Addiction Treatment, Recovery, & Prevention, and Problem Gambling Services.

(e) **Criminal Justice Involvement:** This measure will be monitored by OHA for Individuals referred by the justice system. The measure is expressed as the number of Individuals who were not arrested after an episode of active treatment or two consecutive quarters (whichever comes first), divided by the total number of Individuals referred by the justice system. This measure applies to all program areas; Community Mental Health, Addiction Treatment, Recovery, & Prevention, and Problem Gambling Services.

(f) **Oregon State Hospital (OSH) Ready to Transition List (RTT):** All Contractors need to work together to make sure when an Individual is deemed Ready To Transition, they are discharged timely and with the appropriate Services and supports. This measure will be calculated by identifying the length of time from RTT to discharge for Individuals at OSH under civil commitment.

This measure applies only to Community Mental Health services.

9. Upon OHA's identification of any deficiencies in the County's performance under this Agreement, including without limitation failure to submit reports as required, failure to expend available funding, or failure to meet performance requirements, County shall prepare and submit to OHA within 30 calendar days a Corrective Action Plan (CAP) to be reviewed and approved by OHA. The CAP shall include, but is not limited to, the following information:

a. Reason or reasons for the CAP;

b. The date the CAP will become effective, with timelines for implementation;

c. Planned action already taken to correct the deficiencies, as well as proposed resolutions to address remaining deficits identified, with oversight and monitoring by OHA; and

d. Proposed remedies, short of termination, should County not come into compliance within the timeframe set forth in the CAP.

10. Reporting Requirement for MOTS

All Individuals receiving Services for A&D 03, 61, 62, 63, 64, 65, 66, 67, and MHS 01, 04, 05, 08, 09, 13, 15, 20, 25, 26, 27, 28, 30, 34, 35, 36, 38, 39 with funds provided through this Agreement must be enrolled and that Individual's record maintained in the Measures and Outcomes Tracking System (MOTS) as specified in OHA's MOTS Reference Manual located, at: http://www/oregon.gov/OHA/HSD/AMH-MOTS/pages/resource.aspx, and the Who Reports in MOTS Policy, as follows:

The data collection system for the Health Systems Division (HSD) is the Measures and Outcomes Tracking System or MOTS. In general, behavioral health providers who are either licensed or have a letter of approval from the HSD (or the former Addictions & Mental Health Division [AMH], and receive public funds to provide treatment services are required to report to MOTS. In addition to the general rule above, there are four basic ways to classify who is required to submit data to MOTS:

a. Providers with HSD contracts that deliver treatment services (this includes Community Mental Health Programs [CMHP], Local Mental Health Authorities [LMHA] and other

types of community behavioral health providers); these programs shall all have a license or letter of approval form the HSD or AMH;

b. Providers that are subcontractors (can be a subcontractor or a CMHP or other entity that holds a contract with HSD or OHA, such as a Mental Health Organization [MHO], or a Coordinated Care Organization [CCO]);

c. Providers that HSD does not contract with but are required to submit data to MOTS by State/Federal statute or rule; these include DUII services providers and methadone maintenance providers; and

d. Providers that contract with other governmental agencies (e.g., Oregon Youth Authority [OYA] or the Department of Corrections [DOC] to deliver mental health and /or substance abuse services).

e.Primary care physicians that provide a single service on behalf of the CMHP are not required to report the MOTS status or service level data.

If there are any questions, contact MOTS Support at MOTS.Support@state.or.us.

2021 INTERGOVERNMENTAL AGREEMENT
FOR THE FINANCING OF COMMUNITY MENTAL HEALTH, ADDICTION TREATMENT, RECOVERY, & PREVENTION, AND PROBLEM GAMBLING SERVICES

EXHIBIT F
GENERAL TERMS AND CONDITIONS

1. Disbursement and Recovery of Financial Assistance.

a. Disbursement Generally. Subject to the conditions precedent set forth below, OHA shall disburse the financial assistance described in the Financial Assistance Award to County in accordance with the procedures set forth below and, as applicable, in the Service Descriptions and the Financial Assistance Award. Disbursement procedures may vary by Service.

(1) Disbursement of Financial Assistance Awarded for Services in Financial Assistance Award. As set forth in the Service Description for a particular Service, OHA will generally disburse financial assistance that is described in the Financial Assistance Award to County in monthly allotments in advance of actual delivery of the Service.

(2) Disbursements Remain Subject to Recovery. All disbursements of financial assistance under this Agreement, including disbursements made directly to Providers, remain subject to recovery from County, in accordance with Recovery of Financial Assistance section below.

b. Conditions Precedent to Disbursement. OHA's obligation to disburse financial assistance to County under this Agreement is subject to satisfaction, with respect to each disbursement, of each of the following conditions precedent:

(1) No County default, as described in Section 6 of Exhibit G, "Standard Terms and Conditions," has occurred.

(2) County's representations and warranties, as set forth in Section 4 of Exhibit G, "Standard Terms and Conditions," are true and correct on the date of disbursement with the same effect as though made on the date of disbursement.

c. Recovery of Financial Assistance.

(1) Notice of Underexpenditure, Overexpenditure. If OHA believes there has been an Underexpenditure or Overexpenditure (as defined in Exhibit A "Definitions") of moneys disbursed under this Agreement, OHA shall provide County with written notice thereof, with a detailed spreadsheet providing supporting data of an under or over expenditure, and OHA and County shall engage in the process described in the Recovery of Underexpenditure or Overexpenditure section below. If OHA believes there has been a Misexpenditure (as defined in Exhibit A "Definitions") of moneys disbursed to County under this Agreement, OHA shall provide County with written notice thereof and OHA and County shall engage in the process described in Recovery of Misexpenditures section below.

(2) Recovery of Underexpenditure or Overexpenditure.

(a) County's Response. County shall have 90 calendar days from the effective date of the notice of Underexpenditure or Overexpenditure or from the date of receipt of the notice, whichever is later, to pay OHA in full or notify OHA that it wishes to engage in the appeals process set forth in the Appeals Process section below. If County fails to respond within that 90 calendar-day time period, County shall promptly pay the noticed Underexpenditure or Overexpenditure.

(b) Appeals Process. Upon receipt of the final notice, if County notifies OHA that it wishes to engage in the Appeals Process, County and OHA shall engage in non-binding discussions to give the County an opportunity to present reasons why it believes that there was no Underexpenditure or Overexpenditure, or that the amount of the Underexpenditure or Overexpenditure was different than the amount identified by OHA, and to give OHA the opportunity to reconsider its notice. County and OHA may negotiate an appropriate apportionment of responsibility for the repayment of an Underexpenditure or Overexpenditure. At County request, OHA will meet and negotiate with County in good faith concerning appropriate apportionment of responsibility for repayment of an Underexpenditure or Overexpenditure. In determining an appropriate apportionment of responsibility, County and OHA may consider any relevant factors. An example of a relevant factor is the extent to which either party contributed to an interpretation of a statute, regulation or rule prior to the expenditure that was officially reinterpreted after the expenditure. If OHA and County reach agreement on the amount owed to OHA, County shall promptly repay that amount to OHA by issuing payment to OHA or by directing OHA to withhold future payments pursuant to the Recovery from Future Payment section below. If OHA and County are unable to agree to whether there has been an Underexpenditure or Overexpenditure or as to the amount owed, the parties may agree to consider further appropriate dispute resolution processes, including, subject to State of Oregon Department of Justice and County Counsel approval, arbitration. If both parties are unable to agree to further dispute resolution, the parties shall proceed according to the procedures described in the Recovery from Future Payments section below.

(c) Recovery from Future Payments. To the extent that OHA is entitled to recover an Underexpenditure or Overexpenditure pursuant to this Recovery of Underexpenditure or Overexpenditure section, OHA may recover the Underexpenditure or Overexpenditure by offsetting the amount thereof against future amounts owed to County by OHA, including, but not limited to, any amount owed to County by OHA under any other agreement between County and OHA, present or future. OHA shall provide County written notice of its intent to recover the amount of the Underexpenditure or Overexpenditure from amounts owed County by OHA as set forth in this Section and shall identify the amounts, which OHA intends to offset, (including the agreements, if any, under which the amounts owed arose and from those from which OHA wishes to deduct payments). County shall then have 14 calendar days from the date of OHA's notice in which to request the deduction be made from other amounts owed to County by

OHA and identified by County. OHA shall comply with County's request for alternate offset. In the event that OHA and County are unable to agree on which specific amounts, owed to County by OHA, OHA may offset in order to recover the amount of the Underexpenditure or Overexpenditure, OHA may select the particular agreements, between OHA and County, and amounts from which it will recover the Underexpenditure or Overexpenditure, after providing notice to the County and subject to the following limitations: OHA shall first look to amounts owed to County (but unpaid) under this Agreement. If that amount is insufficient, then OHA may look to any other amounts currently owing or owed in the future to County by OHA. In no case, without the prior consent of County, shall OHA deduct from any one payment due to County under the agreement from which OHA is offsetting funds an amount in excess of twenty-five percent (25%) of that payment. OHA may look to as many future payments as necessary in order to fully recover the amount of the Underexpenditure or Overexpenditure.

(3) Recovery of Misexpenditure.

(a) If OHA believes there has been a Misexpenditure (as defined in Exhibit A "Definitions") of money disbursed to County under this Agreement, OHA shall provide to County a written notice of recovery, with a detailed spreadsheet providing supporting data of the Misexpenditure attached, and OHA and County shall engage in the process described in the Appeal Process section below.

(b) **County's Response.** From the effective date of the Misexpenditure notice or from the date of receipt of notice, whichever is later, County shall have the lesser of 60 calendar days; or if a Misexpenditure relates to a federal government request for reimbursement, 30 calendar days fewer than the number of days (if any) OHA has to appeal a final written decision from the federal government, to either:

i. Make a payment to OHA in the full amount of the Misexpenditure as identified by OHA in the notice; or

ii. Notify OHA that County wishes to repay the amount of the Misexpenditure, as identified by OHA in the notice, from future payments pursuant to the Recovery from Future Payments section below; or

iii. Notify OHA that it wishes to engage in the applicable appeal process, as set forth in the Appeal Process section below.

If County fails to respond within the time required by this Section, OHA may recover the amount of the Misexpenditure identified in the notice from future payments as set forth in Recovery from Future Payment section below.

(c) **Appeal Process.** If County notifies OHA that it wishes to engage in an appeal process with respect to a notice of Misexpenditure from OHA, the parties shall comply with the following procedures, as applicable:

i. **Appeal from OHA-Identified Misexpenditure.** If OHA's notice of Misexpenditure is based on a Misexpenditure solely of the type described in Section 20(b) or (c) of Exhibit A, "Definitions," County and OHA shall engage in the process described in this Appeal Process section to resolve a dispute regarding the notice of Misexpenditure. First, County and OHA shall engage in non-binding discussions, to give the County an opportunity to present reasons why it believes that there is, in fact, no Misexpenditure or that the amount of the Misexpenditure is different than the amount identified by OHA in the notice, and to give OHA the opportunity to reconsider its notice. County and OHA may negotiate an appropriate apportionment of responsibility for the repayment of the Misexpenditure. At County's request, OHA will meet and negotiate with County in good faith concerning appropriate apportionment of responsibility for repayment of the Misexpenditure. In determining an appropriate apportionment of responsibility, County and OHA may consider any relevant factors. An example of a relevant factor is the extent to which either party contributed to an interpretation of a statute, regulation or rule prior to the expenditure that was officially reinterpreted after the expenditure. If OHA and County reach agreement on the amount owed to OHA, County shall promptly repay that amount to OHA by issuing payment to OHA or by directing OHA to withhold future payments pursuant to the Recovery from Future Payments section below. If OHA and County continue to disagree as to whether there has been a Misexpenditure or as to the amount owed, the parties may agree to consider further appropriate dispute resolution processes, including, subject to State of Oregon Department of Justice and County Counsel approval, arbitration.

ii. **Appeal from Federal-Identified Misexpenditure**.

A. If OHA's notice of Misexpenditure is based on a Misexpenditure of the type described in Section 20(a) of Exhibit A, "Definitions," and the relevant federal agency provides a process either by statute or administrative rule to appeal the determination of improper use of federal funds, the notice of disallowance or other federal identification of improper use of funds, and if the disallowance is not based on a federal or state court judgment founded in allegations of Medicaid fraud or abuse, then County may, 30 calendar days prior to the applicable federal appeals deadline, request that OHA appeal the determination of improper use, notice of disallowance or other federal identification of improper use of funds in accordance with the process established or adopted by the federal agency. If County so requests that OHA appeal the determination of improper use of federal

funds, federal notice of disallowance or other federal identification of improper use of funds, the amount in controversy shall, at the option of County, be retained by the County or returned to OHA pending the final federal decision resulting from the initial appeal. If the County requests, prior to the deadline set forth above, that OHA appeal, OHA shall appeal the determination of improper use, notice of disallowance or other federal identification of improper use of funds in accordance with the established process and shall pursue the appeal until a decision is issued by the Departmental Grant Appeals Board of the Department of Health and Human Services (the "Grant Appeals Board") pursuant to the process for appeal set forth in 45 C.F.R. Subtitle A, Part 16, or an equivalent decision is issued under the appeal process established or adopted by the federal agency. County and OHA shall cooperate with each other in pursuing the appeal. If the Grant Appeals Board or its equivalent denies the appeal then either County, OHA, or both may, at their discretion, pursue further appeals. Regardless of any further appeals, within 90 calendar days of the date the federal decision resulting from the initial appeal is final, County shall repay to OHA the amount of the Misexpenditure (reduced, if at all, as a result of the appeal) by issuing payment to OHA or by directing OHA to withhold future payments pursuant to Recovery from Future Payments section below. To the extent that County retained any of the amount in controversy while the appeal was pending, the County shall also pay to OHA the interest, if any, charged by the federal government on such amount.

B. If the relevant federal agency does not provide a process either by statute or administrative rule to appeal the determination of improper use of federal funds, the notice of disallowance or other federal identification of improper use of funds or County does not request that OHA pursue an appeal 30 calendar days prior to the applicable federal appeals deadline, and if OHA does not appeal, within 90 calendar days of the date the federal determination of improper use of federal funds, the federal notice of disallowance or other federal identification of improper use of funds is final, County shall repay to OHA the amount of the Misexpenditure by issuing a payment to OHA or by directing OHA to withhold future payments pursuant to the Recovery from Future Payments section below.

C. If County does not request that OHA pursue an appeal of the determination of improper use of federal funds, the notice of disallowance or other federal identification of improper use of funds 30 calendar days prior to the applicable federal appeals deadline but OHA nevertheless appeals, County shall repay to OHA the amount of the Misexpenditure (reduced, if at all, as a result of the appeal), within 90 calendar days of the date the federal decision resulting from the appeal is final, by issuing payment to OHA or by directing OHA to withhold future payments pursuant to the Recovery from Future Payments section below.

D. Notwithstanding County's Response section above, if the Misexpenditure was expressly authorized by OHA rule or an OHA writing that applied when the expenditure was made but was prohibited by federal statutes or regulations that applied when the expenditure was made, County will not be responsible for repaying the amount of the Misexpenditure to OHA, provided that:

I. Where post-expenditure official reinterpretation of federal statutes or regulations results in a Misexpenditure, County and OHA will meet and negotiate in good faith an appropriate apportionment of responsibility between them for repayment of the Misexpenditure.

II. For purposes of this Section, an OHA writing must interpret this Agreement or OHA rule and be signed by the Director of OHA, the Director of Health Systems Division or the Section Director.

OHA shall designate an alternate officer in the event the Health Systems Division is abolished. Upon County's request, OHA shall notify County of the names of the individual officers listed above. OHA shall send OHA writings described in this paragraph to County by mail and email and to CMHP directors by email.

III. The OHA writing must be in response to a request from County for expenditure authorization or a statement intended to provide official guidance to County or counties generally for making expenditures under this Agreement. The writing must not be contrary to this Agreement or contrary to law or other applicable authority that is clearly established at the time of the OHA writing.

IV. If the OHA writing is in response to a request from County for expenditure authorization, the County's request must be in writing and signed by the director of a County department with the authority to make such a request or by the County Counsel. It must identify the supporting data, provisions of this Agreement and provisions of applicable law relevant to determining if the expenditure should be authorized.

V. An OHA writing expires on the date stated in the writing, or if no expiration date is stated, six years from the date of the writing. An expired OHA writing continues to apply to County expenditures that were made in compliance with the writing and during the term of the writing.

VI. OHA may revoke or revise an OHA writing at any time if it determines in its sole discretion that the writing allowed expenditure in violation of this Agreement, law, or any other applicable authority. However, County is not responsible for a misexpenditure that was based on an OHA writing that was effective at the time of the misexpenditure.

VII. OHA rule does not authorize an expenditure that this Agreement prohibits.

(d) **Recovery from Future Payments.** To the extent that OHA is entitled to recover a Misexpenditure pursuant to the Appeal Process section above, OHA may recover the Misexpenditure by offsetting the amount thereof against future amounts owed to County by OHA, including, but not limited to, any amount owed to County by OHA under this Agreement or any amount owed to County by OHA under any other agreement between County and OHA, present or future. OHA shall provide County written notice of its intent to recover the amount of the Misexpenditure from amounts owed County by OHA as set forth in this Section, and shall identify the amounts owed by OHA which OHA intends to offset (including the agreements, if any, under which the amounts owed arose and from those from which OHA wishes to deduct payments). County shall then have 14 calendar days from the date of OHA's notice to request the deduction be made from other amounts owed to County by OHA and identified by County. OHA shall comply with County's request for alternate offset. In the event that OHA and County are unable to agree on which specific amounts, owed to County by OHA, OHA may offset in order to recover the amount of the Misexpenditure, then OHA may select the particular agreements between OHA and County and amounts from which it will recover the amount of the Misexpenditure, after providing notice to the County, and subject to the following limitations: OHA shall first look to amounts owed to County (but unpaid) under this Agreement. If that amount is insufficient, then OHA may look to any other amounts currently owing or owed in the future to County by OHA. In no case, without the prior consent

of County, shall OHA deduct from any one payment due County under the agreement from which OHA is offsetting funds an amount in excess of twenty-five percent (25%) of that payment. OHA may look to as many future payments as necessary in order to fully recover the amount of the Misexpenditure.

(4) Additional Provisions related to parties' rights and obligations with respect to Underexpenditures, Overexpenditures and Misexpenditures.

(a) County shall cooperate with OHA in the Agreement Settlement process.

(b) OHA's right to recover Underexpenditures, Overexpenditures and Misexpenditures from County under this Agreement is not subject to or conditioned upon County's recovery of any money from any other entity.

(c) If the exercise of OHA's right to offset under this provision requires the County to complete a re-budgeting process, nothing in this provision shall be construed to prevent the County from fully complying with its budgeting procedures and obligations, or from implementing decisions resulting from those procedures and obligations.

(d) Nothing in this provision shall be construed as a requirement or agreement by the County to negotiate and execute any future contract with OHA.

(e) Nothing in this Section shall be construed as a waiver by either party of any process or remedy that might otherwise be available.

2. Use of Financial Assistance. County shall use the financial assistance disbursed to County under this Agreement solely to cover actual Allowable Costs reasonably and necessarily incurred to deliver Services during the term of this Agreement.

3. Award Adjustments

a. County may use funds awarded in a Program Area to cover actual Allowable Costs reasonably and necessarily incurred to deliver Services in that Program Area, from the Effective Date of this Agreement through the termination or expiration of this Agreement. In addition to the financial assistance provided to County under this Agreement expressly for those Services, up to 10 percent of the aggregate financial assistance awarded to County at the time the use occurs (as such award is reflected in the Financial Assistance Award without giving effect to any prior adjustments under this Award Adjustments section and other than from Federal Funds) County may use funds for other Services in that Program Area (other than financial assistance provided to County for MHS 04, MHS 05, MHS 08, MHS 09, MHS 10, MHS 12, MHS 13, MHS 15, MHS 26, MHS 27, MHS 28, MHS 37, A&D 60, A&D 61, A&D 62, A&D 65, A&D 80, A&D 81, A&D 82, A&D 83 and A&D 84, which is not subject to this 10 percent use adjustment). If County uses financial assistance described in the Financial Assistance Award in reliance on this Award Adjustments section, County shall promptly notify in writing of such use.

b. Financial assistance disbursed to County under this Agreement that County would be entitled to retain if used prior to the termination or expiration of this Agreement (as calculated in accordance with the methodologies set forth in the applicable Service Descriptions), may be retained by County even if not used prior to the termination or expiration of this Agreement provided that other provisions of this Agreement do not require the financial assistance to be used by County prior to termination or expiration of

this Agreement and provided further that County uses the financial assistance solely to deliver future Services for the purpose it was originally awarded.

4. **Amendments Proposed by OHA.**

a. **Amendments of Financial Assistance Award.** County shall review all proposed amendments to the Financial Assistance Award prepared and presented to County by OHA in accordance with this Section. Amendments to the Financial Assistance Award will be presented to County in electronic form. OHA may withdraw a proposed amendment by and effective upon written notice to County. If not sooner accepted or rejected by County, or withdrawn by OHA, a proposed amendment shall be deemed rejected by County 60 calendar days after County's receipt thereof and OHA's offer to amend the Financial Assistance Award shall be automatically revoked. If County chooses to accept a proposed amendment presented in electronic form, County shall return the proposed amendment to OHA signed by the County Financial Assistance Administrator. Upon OHA's actual physical receipt and signature of a proposed amendment signed by the County Financial Assistance Administrator but otherwise unaltered, the proposed amendment shall be considered accepted by the parties and the Financial Assistance Award, as amended by the proposed amendment, shall become the Financial Assistance Award under this Agreement. If County returns a proposed amendment altered in any way (other than by signature of the County Financial Assistance Administrator), OHA may, in its discretion, accept the proposed amendment as altered by County but only if the County Financial Assistance Administrator has initialed each alteration. A proposed amendment altered by County and returned to OHA shall be considered accepted by OHA on the date OHA initials each alteration and on that date the Financial Assistance Award, as amended by the proposed amendment (as altered), shall become the Financial Assistance Award.

b. **Other Amendments.** County shall review all proposed amendments to this Agreement prepared and presented to County by OHA, other than those described in the previous subsection a., promptly after County's receipt thereof. If County does not accept a proposed amendment within 60 calendar days of County's receipt thereof, County shall be deemed to have rejected the proposed amendment and the offer to amend the Agreement, as set forth in the proposed amendment, shall be automatically revoked. If County chooses to accept the proposed amendment, County shall return the proposed amendment to OHA signed by a duly authorized County official. Upon OHA's actual physical receipt and signature of a proposed amendment signed by a duly authorized County official but otherwise unaltered, the proposed amendment shall be considered accepted by the parties and this Agreement shall be considered amended as set forth in the accepted amendment. If County returns a proposed amendment altered in any way (other than by signature of a duly authorized County official), OHA may, in its discretion, accept the proposed amendment as altered by County but only if a duly authorized County official has initialed each alternation. A proposed amendment altered by County and returned to OHA shall be considered accepted by OHA on the date OHA initials each alteration and on that date this Agreement shall be considered amended as set forth in the accepted amendment.

5. **Provider Contracts**. Except when the Service expressly requires the Service or a portion thereof to be delivered by County directly and subject to the Provider Monitoring section below, County may use financial assistance provided under this Agreement for a particular Service to purchase that Service, or a portion thereof, from a third person or entity (a "Provider") through a contract (a "Provider Contract"). Subject to the Provider Monitoring section below, County may permit a Provider to purchase the Service, or a portion thereof, from another person or entity under a subcontract and such subcontractors shall also be considered Providers for purposes of this Agreement and those subcontracts shall be considered Provider Contracts under this Agreement. County shall not permit any person or entity to be a Provider unless the person or entity holds all licenses, certificates, authorizations and other approvals required by applicable law to deliver the Service. If County purchases a Service, or portion thereof, from a Provider, the Provider Contract must be in writing, identify for sub-recipients the amount of federal funds included in the Provider Contract, provide the CFDA number, and contain each of the provisions set forth in Exhibit I, "Required Provider Contract Provisions," in substantially the form set forth therein, in addition to any other provisions that must be included to comply with applicable law, that must be included in a Provider Contract under the terms of this Agreement or that are necessary to implement Service delivery in accordance with the applicable Service Descriptions, Specialized Service Requirements and Special Conditions. County shall maintain an originally executed copy of each Provider Contract at its office and shall furnish a copy of any Provider Contract to OHA upon request.

6. **Provider Monitoring.** County shall monitor each Provider's delivery of Services and promptly report to OHA when County identifies a deficiency in a Provider's delivery of a Service or in a Provider's compliance with the Provider Contract between the Provider and County. County shall promptly take all necessary action to remedy any identified deficiency on the part of the Provider. County shall also monitor the fiscal performance of each Provider and shall take all lawful management and legal action necessary to pursue this responsibility. In the event of a deficiency in a Provider's delivery of a Service or in a Provider's compliance with the Provider Contract between the Provider and County, nothing in this Agreement shall limit or qualify any right or authority OHA has under state or federal law to take action directly against the Provider.

7. **Alternative Formats and Translation of Written Materials, Interpreter Services.**

In connection with the delivery of Program Element services, County shall make available to Client, without charge, upon the Client's reasonable request:

a. All written materials related to the services provided to the Client in alternate formats.

b. All written materials related to the services provided to the Client in the Client's language.

c. Oral interpretation services related to the services provided to the Client in the Client's language.

d. Sign language interpretation services and telephone communications access services related to the services provided to the Client.

For purposes of the foregoing, "written materials" means materials created by County, in connection with the Service being provided to the requestor. The County may develop its own forms and materials and with such forms and materials the County shall be responsible for making them available to a Client, without charge to the Client in the prevalent non-English language(s) within the County service area. OHA shall be responsible for making its forms and materials available, without charge to the Client or County, in the prevalent non-English language(s) within the County service area.

8. **Reporting Requirements.** If County delivers a Service directly, County shall prepare and furnish the following information to OHA when that Service is delivered:

   a. Client, Service and financial information as specified in the Service Description.

   b. All additional information and reports that OHA reasonably requests.

9. **Operation of CMHP**. County shall operate or contract for the operation of a CMHP during the term of this Agreement. If County uses funds provided under this Agreement for a particular Service, County shall include that Service in its CMHP from the date it begins using the funds for that Service until the earlier of: (a) termination or expiration of this Agreement; (b) termination by OHA of OHA's obligation to provide financial assistance for that Service in accordance with Exhibit G, Termination section; or (c) termination by the County, in accordance with Exhibit G, Termination section, of County's obligation to include in its CMHP a Program Area that includes that Service.

10. **OHA Reports.**

   a. To the extent resources are available to OHA to prepare and deliver the information, OHA shall, during the term of this Agreement, provide County with the following reports:

      (1) Summary reports to County and County's Providers from MOTS data as reported to OHA under this Agreement; and

      (2) Monthly reports to County that detail disbursement of financial assistance under the Financial Assistance Award in Exhibit C for the delivery of Services.

   b. OHA shall prepare and send to each Provider to whom OHA makes direct payments on behalf of County under this Agreement during a calendar year, an IRS Form 1099 for that year specifying the total payments made by OHA to that Provider.

11. **Technical Assistance**. During the term of this Agreement, OHA shall provide technical assistance to County in the delivery of Services to the extent resources are available to OHA for this purpose. If the provision of technical assistance to the County concerns a Provider, OHA may require, as a condition to providing the assistance, that County take all action with respect to the Provider reasonably necessary to facilitate the technical assistance.

12. **Payment of Certain Expenses**. If OHA requests that an employee of County or a Provider or a citizen of County attend OHA training or an OHA conference or business meeting and County has obligated itself to reimburse the individual for travel expenses incurred by the individual in attending the training or conference, OHA may pay those travel expenses on behalf of County but only at the rates and in accordance with the reimbursement procedures set forth in the Oregon Accounting Manual (http://www.oregon.gov/das/Financial/Acctng/Pages/oam.aspx) under 40.10.00 as of the date the expense was incurred and only to the extent that OHA determines funds are available for such reimbursement.

13. **Effect of Amendments Reducing Financial Assistance.** If County and OHA amend this Agreement to reduce the amount of financial assistance awarded for a particular Service, County is not required by this Agreement to utilize other County funds to replace the funds no longer received under this Agreement as a result of the amendment and County may, from and after the date of the amendment, reduce the quantity of that Service included in its CMHP commensurate with the amount of the reduction in financial assistance awarded for that Service. Nothing in the preceding sentence shall affect County's obligations under this Agreement with respect to financial assistance actually disbursed by OHA under this Agreement or with respect to Services actually delivered.

14. **Resolution of Disputes over Additional Financial Assistance Owed County After Termination or Expiration.** If, after termination or expiration of this Agreement, County believes that OHA disbursements of financial assistance under this Agreement for a particular Service are less than the amount of financial assistance that OHA is obligated to provide to County under this Agreement for that Service, as determined in accordance with the applicable financial assistance calculation methodology, County shall provide OHA with written notice thereof. OHA shall have 90 calendar days from the effective date of County's notice to pay County in full or notify County that it wishes to engage in a dispute resolution process. If OHA notifies County that it wishes to engage in a dispute resolution process, County and OHA's Chief Health Systems Officer for the Health Systems Division shall engage in non-binding discussion to give OHA an opportunity to present reasons why it believes that it does not owe County any additional financial assistance or that the amount owed is different than the amount identified by County in its notices, and to give County the opportunity to reconsider its notice. If OHA and County reach agreement on the additional amount owed to County, OHA shall promptly pay that amount to County. If OHA and County continue to disagree as to the amount owed, the parties may agree to consider further appropriate dispute resolution processes, including, subject to Department of Justice and County Counsel approval, binding arbitration. Nothing in this Section shall preclude the County from raising underpayment concerns at any time prior to termination or expiration of this Agreement under Alternative Dispute Resolution below.

15. **Alternative Dispute Resolution.** The parties should attempt in good faith to resolve any dispute arising out of this agreement. This may be done at any management level, including at a level higher than persons directly responsible for administration of the agreement. In addition, the parties may agree to utilize a jointly selected mediator or arbitrator (for non-binding arbitration) to resolve the dispute short of litigation.

16. **Purchase and Disposition of Equipment.**

    a. For purposes of this Section, "Equipment" means tangible, non-expendable personal property having a useful life of more than one year and a net acquisition cost of more than $5,000 per unit. However, for purposes of information technology equipment, the monetary threshold does not apply (except as provided below for Software and storage devices). Information technology equipment shall be tracked for the mandatory line categories listed below:

        (1) Network;

        (2) Personal Computer;

        (3) Printer/Plotter;

        (4) Server;

(5) Storage device that will contain client information;

(6) Storage device that will not contain client information, when the acquisition cost is $100 or more; and

(7) Software, when the acquisition cost is $100 or more.

b. For any Equipment authorized by OHA for purchase with funds from this Agreement, ownership shall be in the name of the County and County is required to accurately maintain the following Equipment inventory records:

(1) Description of the Equipment;

(2) Serial number;

(3) Where Equipment was purchased;

(4) Acquisition cost and date; and

(5) Location, use, and condition of the Equipment.

County shall provide the Equipment inventory list electronically to the Agreement Administrator at amhcontract.administrator@state.or.us by June 30th of the first fiscal year and at the end of the remainder of the term of this Contract. County shall be responsible to safeguard any Equipment and maintain the Equipment in good repair and condition while in the possession of County or any Providers. County shall depreciate all Equipment, with a value of more than $5,000, using the straight-line method.

c. Upon termination of this Agreement, or any Service thereof, for any reason whatsoever, County shall, upon request by OHA, immediately, or at such later date specified by OHA, tender to OHA any and all Equipment purchased with funds under this Agreement as OHA may require to be returned to the State. At OHA's direction, County may be required to deliver said Equipment to a subsequent contractor for that contractor's use in the delivery of Services formerly provided by County. Upon mutual agreement, in lieu of requiring County to tender the Equipment to OHA or to a subsequent contractor, OHA may require County to pay to OHA the current value of the Equipment. Equipment value will be determined as of the date of Agreement or Service termination.

d. If funds from this Agreement are authorized by OHA to be used as a portion of the purchase price of Equipment, requirements relating to title, maintenance, Equipment inventory reporting and residual value shall be negotiated, and the agreement reflected in a Special Condition authorizing the purchase.

e. Notwithstanding anything herein to the contrary, County shall comply with 45 CFR 75.320, which generally describes the required maintenance, documentation, and allowed disposition of equipment purchased with federal grant funds.

17. Nothing in this Agreement shall cause or require County or OHA to act in violation of state or federal constitutions, statutes, regulations or rules. The parties intend this limitation to apply in addition to any other limitation in this Agreement, including limitations in Disbursement and Recovery of Financial Assistance above.

2021 INTERGOVERNMENTAL AGREEMENT
FOR THE FINANCING OF COMMUNITY MENTAL HEALTH, ADDICTION TREATMENT, RECOVERY, & PREVENTION, AND PROBLEM GAMBLING SERVICES

EXHIBIT G
STANDARD TERMS AND CONDITIONS

1. **Governing Law, Consent to Jurisdiction.** This Agreement shall be governed by and construed in accordance with the laws of the State of Oregon without regard to principles of conflicts of law. Any claim, action, suit or proceeding (collectively, "Claim") between the parties that arises from or relates to this Agreement shall be brought and conducted solely and exclusively within a circuit court for the State of Oregon of proper jurisdiction. THE PARTIES, BY EXECUTION OF THIS AGREEMENT, HEREBY CONSENT TO THE IN PERSONAM JURISDICTION OF SAID COURTS. Except as provided in this section, neither party waives any form of defense or immunity, whether sovereign immunity, governmental immunity, immunity based on the eleventh amendment to the Constitution of the United States or otherwise, from any Claim or from the jurisdiction of any court. The parties acknowledge that this is a binding and enforceable agreement and, to the extent permitted by law, expressly waive any defense alleging that either party does not have the right to seek judicial enforcement of this Agreement.

2. **Compliance with Law.** Both parties shall comply with laws, regulations and executive orders to which they are subject and which are applicable to the Agreement or to the delivery of Services. Without limiting the generality of the foregoing, both parties expressly agree to comply with the following laws, rules, regulations and executive orders to the extent they are applicable to the Agreement: (a) OAR 943-005-0000 through 943-005-0070, prohibiting discrimination against Individuals with disabilities, as may be revised, and all applicable requirements of state civil rights and rehabilitation statutes, rules and regulations; (b) all state laws governing operation of Community Mental Health Programs, including without limitation, all administrative rules adopted by OHA related to Community Mental Health Programs or related to client rights; (c) all state laws requiring reporting of Client abuse; and (d) ORS 659A.400 to 659A.409, ORS 659A.145, (e) 45 CFR 164 Subpart C, and all regulations and administrative rules established pursuant to those laws in the construction, remodeling, maintenance and operation of any structures and facilities, and in the conduct of all programs, services and training associated with the delivery of Services. These laws, regulations and executive orders are incorporated by reference herein to the extent that they are applicable to the Agreement and required by law to be so incorporated. All employers, including County and OHA that employ subject workers who provide Services in the State of Oregon shall comply with ORS 656.017 and provide the required Workers' Compensation coverage, unless such employers are exempt under ORS 656.126.

3. **Independent Contractors.** The parties agree and acknowledge that their relationship is that of independent contracting parties and that County is not an officer, employee, or agent of the State of Oregon as those terms are used in ORS 30.265 or otherwise.

4. **Representations and Warranties.**

   a. County represents and warrants as follows:

   (1) Organization and Authority. County is a political subdivision of the State of Oregon duly organized and validly existing under the laws of the State of Oregon. County has full power, authority and legal right to make this Agreement and to incur and perform its obligations hereunder.

(2) **Due Authorization**. The making and performance by County of this Agreement: (a) have been duly authorized by all necessary action by County; (b) do not and will not violate any provision of any applicable law, rule, regulation, or order of any court, regulatory commission, board, or other administrative agency or any provision of County's charter or other organizational document; and (c) do not and will not result in the breach of, or constitute a default or require any consent under any other agreement or instrument to which County is a party or by which County may be bound or affected. No authorization, consent, license, approval of, filing or registration with or notification to any governmental body or regulatory or supervisory authority is required for the execution, delivery or performance by County of this Agreement.

(3) **Binding Obligation**. This Agreement has been duly executed and delivered by County and constitutes a legal, valid and binding obligation of County, enforceable in accordance with its terms subject to the laws of bankruptcy, insolvency, or other similar laws affecting the enforcement of creditors' rights generally.

(4) County has the skill and knowledge possessed by well-informed members of its industry, trade or profession and County will apply that skill and knowledge with care and diligence to perform the Services in a professional manner and in accordance with standards prevalent in County's industry, trade or profession;

(5) County shall, at all times during the term of this Agreement, be qualified, professionally competent, and duly licensed to perform the Services; and

(6) County prepared its proposal related to this Agreement, if any, independently from all other proposers, and without collusion, fraud, or other dishonesty.

(7) **Services**. To the extent Services are performed by County, the delivery of each Service will comply with the terms and conditions of this Agreement and meet the standards for such Service as set forth herein, including but not limited to, any terms, conditions, standards and requirements set forth in the Financial Assistance Award, applicable Service Description and applicable Specialized Service Requirement.

b. OHA represents and warrants as follows:

(1) **Organization and Authority**. OHA has full power, authority and legal right to make this Agreement and to incur and perform its obligations hereunder.

(2) **Due Authorization.** The making and performance by OHA of this Agreement: (a) have been duly authorized by all necessary action by OHA; (b) do not and will not violate any provision of any applicable law, rule, regulation, or order of any court, regulatory commission, board, or other administrative agency; and (c) do not and will not result in the breach of, or constitute a default or require any consent under any other agreement or instrument to which OHA is a party or by which OHA may be bound or affected. No authorization, consent, license, approval of, filing or registration with or notification to any governmental body or regulatory or supervisory authority is required for the execution, delivery or performance by OHA of this Agreement, other than approval by the Department of Justice if required by law.

(3) **Binding Obligation**. This Agreement has been duly executed and delivered by OHA and constitutes a legal, valid and binding obligation of OHA, enforceable in accordance with its terms subject to the laws of bankruptcy, insolvency, or other similar laws affecting the enforcement of creditors' rights generally.

c. **Warranties Cumulative**. The warranties set forth in this section are in addition to, and not in lieu of, any other warranties provided.

5. **Ownership of Intellectual Property.**

a. Except as otherwise expressly provided herein, or as otherwise required by state or federal law, OHA will not own the right, title and interest in any intellectual property created or delivered by County or a Provider in connection with the Services. With respect to that portion of the intellectual property that the County owns, County grants to OHA a perpetual, worldwide, non-exclusive, royalty-free and irrevocable license, subject to any provisions in the Agreement that restrict or prohibit dissemination or disclosure of information, to: (1) use, reproduce, prepare derivative works based upon, distribute copies of, perform and display the intellectual property; (2) authorize third parties to exercise the rights set forth in Section 5.a.(1) on OHA's behalf; and (3) sublicense to third parties the rights set forth in Section 5.a.(1).

b. If state or federal law requires that OHA or County grant to the United States a license to any intellectual property, or if state or federal law requires that OHA or the United States own the intellectual property, then County shall execute such further documents and instruments as OHA may reasonably request in order to make any such grant or to assign ownership in the intellectual property to the United States or OHA. To the extent that OHA becomes the owner of any intellectual property created or delivered by County in connection with the Services, OHA will grant a perpetual, worldwide, non-exclusive, royalty-free and irrevocable license, subject to any provisions in the Agreement that restrict or prohibit dissemination or disclosure of information, to County to use, copy, distribute, display, build upon and improve the intellectual property.

c. County shall include in its Provider Contracts terms and conditions necessary to require that Providers execute such further documents and instruments as OHA may reasonably request in order to make any grant of license or assignment of ownership that may be required by federal or state law.

6. **County Default.** County shall be in default under this Agreement upon the occurrence of any of the following events:

a. County fails to perform, observe or discharge any of its covenants, agreements or obligations set forth herein;

b. Any representation, warranty or statement made by County herein or in any documents or reports made in connection herewith or relied upon by OHA to measure the delivery of Services, the expenditure of financial assistance or the performance by County is untrue in any material respect when made;

c. County: (1) applies for or consents to the appointment of, or taking of possession by, a receiver, custodian, trustee, or liquidator of itself or all of its property; (2) admits in writing its inability, or is generally unable, to pay its debts as they become due; (3) makes a general assignment for the benefit of its creditors; (4) is adjudicated a bankrupt or insolvent; (5) commences a voluntary case under the Federal Bankruptcy Code (as now or hereafter in effect); (6) files a petition seeking to take advantage of any other law relating to bankruptcy, insolvency, reorganization, winding-up, or composition or adjustment of debts; (7) fails to controvert in a timely and appropriate manner, or acquiesces in writing to, any petition filed against it in an involuntary case under the Bankruptcy Code; or (8) takes any action for the purpose of effecting any of the foregoing; or

d. A proceeding or case is commenced, without the application or consent of County, in any court of competent jurisdiction, seeking: (1) the liquidation, dissolution or winding-up, or the composition or readjustment of debts, of County; (2) the appointment of a trustee, receiver, custodian, liquidator, or the like of County or of all or any substantial part of its assets; or (3) similar relief in respect to County under any law relating to bankruptcy, insolvency, reorganization, winding-up, or composition or adjustment of debts, and such proceeding or case continues undismissed, or an order, judgment, or decree approving or ordering any of the foregoing is entered and continues unstayed and in effect for a period of sixty consecutive days, or an order for relief against County is entered in an involuntary case under the Federal Bankruptcy Code (as now or hereafter in effect).

The delivery of any Service fails to comply with the terms and conditions of this Agreement or fails to meet the standards for Service as set forth herein, including but not limited to, any terms, condition, standards and requirements set forth in the Financial Assistance Award and applicable Service Description.

7. **OHA Default.** OHA shall be in default under this Agreement upon the occurrence of any of the following events:

a. OHA fails to perform, observe or discharge any of its covenants, agreements, or obligations set forth herein; or

b. Any representation, warranty or statement made by OHA herein or in any documents or reports made in connection herewith or relied upon by County to measure performance by OHA is untrue in any material respect when made.

8. **Termination.**

a. **County Termination.** County may terminate this Agreement in its entirety or may terminate its obligation to include a particular Program Area in its CMHP:

(1) For its convenience, upon at least three calendar months advance written notice to OHA, with the termination effective as of the first day of the month following the notice period;

(2) Upon 45 calendar days advance written notice to OHA, if County does not obtain funding, appropriations and other expenditure authorizations from County's governing body, federal, state or other sources sufficient to permit County to satisfy its performance obligations under this Agreement, as determined by County in the reasonable exercise of its administrative discretion;

(3) Upon 30 calendar days advance written notice to OHA, if OHA is in default under this Agreement and such default remains uncured at the end of said 30 calendar day period or such longer period, if any, as County may specify in the notice; or

(4) Immediately upon written notice to OHA, if Oregon statutes or federal laws, regulations or guidelines are modified, changed or interpreted by the Oregon Legislative Assembly, the federal government or a court in such a way that County no longer has the authority to meet its obligations under this Agreement.

b. **OHA Termination.** OHA may terminate this Agreement in its entirety or may terminate its obligation to provide financial assistance under this Agreement for one or more particular Services described in the Financial Assistance Award:

(1) For its convenience, upon at least three calendar months advance written notice to County, with the termination effective as of the first day of the month following the notice period;

(2) Upon 45 calendar days advance written notice to County, if OHA does not obtain funding, appropriations and other expenditure authorizations from federal, state or other sources sufficient to meet the payment obligations of OHA under this Agreement, as determined by OHA in the reasonable exercise of its administrative discretion. Notwithstanding the preceding sentence, OHA may terminate this Agreement in its entirety or may terminate its obligation to provide financial assistance under this Agreement for one or more particular Services, immediately upon written notice to County or at such other time as it may determine if action by the Oregon Legislative Assembly or Emergency Board reduces OHA's legislative authorization for expenditure of funds to such a degree that OHA will no longer have sufficient expenditure authority to meet its payment obligations under this Agreement, as determined by OHA in the reasonable exercise of its administrative discretion, and the effective date for such reduction in expenditure authorization is less than 45 calendar days from the date the action is taken;

(3) Immediately upon written notice to County if Oregon statutes or federal laws, regulations or guidelines are modified, changed or interpreted by the Oregon Legislative Assembly, the federal government or a court in such a way that OHA no longer has the authority to meet its obligations under this Agreement or no longer has the authority to provide the financial assistance from the funding source it had planned to use;

(4) Upon 30 calendar days advance written notice to County, if County is in default under this Agreement and such default remains uncured at the end of said 30 calendar day period or such longer period, if any, as OHA may specify in the notice;

(5) Immediately upon written notice to County, if any license or certificate required by law or regulation to be held by County or a Provider to deliver a Service described in the Financial Assistance Award is for any reason denied, revoked, suspended, not renewed or changed in such a way that County or a Provider no longer meets requirements to deliver the Service. This termination right may only be exercised with respect to the particular Service or Services impacted by loss of necessary licensure or certification; or

(6) Immediately upon written notice to County, if OHA reasonably determines that County or any of its Providers have endangered or are endangering the health or safety of a Client or others in performing the Services covered in this Agreement.

c. OHA and County agree that this Agreement extends to March 31, 2022, but only for the purpose of amendments to adjust the allocated budget (Exhibit C, "Financial Assistance Award") for Services performed, or not performed, by County during the 2019-21 biennium and prior to July 1, 2021. If there is more than one amendment modifying the Financial Assistance Award, the amendment shall be applied to the Financial Assistance Award in the order in which the amendments are executed by County and OHA. In no event is the County authorized to provide any Services under this Agreement, and County is not required to provide any Services under this Agreement, after December 31, 2021.

9. Effect of Termination.

a. Entire Agreement.

(1) Upon termination of this Agreement in its entirety, OHA shall have no further obligation to pay or disburse financial assistance to County under this Agreement, whether or not OHA has paid or disbursed to County all financial assistance described in the Financial Assistance Award except: (a) with respect to funds described in the Financial Assistance Award, to the extent OHA's disbursement of financial assistance for a particular Service, the financial assistance for which is calculated on a rate per unit of service or service capacity basis, is less than the applicable rate multiplied by the number of applicable units of Service or Service capacity of that type performed or made available from the effective date of this Agreement through the termination date; and (b) with respect to funds described in the Financial Assistance Award, to the extent OHA's disbursement of financial assistance for a particular Service, the financial assistance for which is calculated on a cost reimbursement basis, is less than the cumulative actual Allowable Costs reasonably and necessarily incurred with respect to delivery of that Service, from the effective date of this Agreement through the termination date.

(2) Upon termination of this Agreement in its entirety, County shall have no further obligation under this Agreement to operate a CMHP.

b. Individual Program Area or Service.

(1) Upon termination of OHA's obligation to provide financial assistance under this Agreement for a particular Service, OHA shall have no further obligation to pay or disburse any financial assistance to County under this Agreement for that Service, whether or not OHA has paid or disbursed to County all financial assistance described in the Financial Assistance Award for that Service except: (a) with respect to funds described in the Financial Assistance Award and if the financial assistance for that Service is calculated on a rate per unit of service or service capacity basis, to the extent that OHA's prior disbursement of financial assistance for that Service is less than the applicable rate multiplied by the number of applicable units of Service or Service capacity of that type performed or made available during the period from the first day of the period for which the funds were awarded through the earlier of the termination of OHA's obligation to provide financial assistance for that Service or the last day of the period for which the funds were awarded; and (b) with respect to funds described in the Financial Assistance Award and if the financial assistance for that Service is calculated on a cost reimbursement basis, to the extent that OHA's prior disbursement of financial assistance for that Service is less than the cumulative actual Allowable Costs reasonably and necessarily incurred by County with respect to delivery of that

Service, during the period from the effective date of this Agreement through the termination of OHA's obligation to provide financial assistance for that Service.

(2) Upon termination of OHA's obligation to provide financial assistance under this Agreement for a particular Service, County shall have no further obligation under this Agreement to include that Service in its CMHP.

(3) Upon termination of County's obligation to include a Program Area in its CMHP, OHA shall have (a) no further obligation to pay or disburse financial assistance to County under this Agreement for System Management and Coordination – Community Mental Health Services (MHS 01) and System Management and Coordination - Addiction Treatment, Recovery, & Prevention, and Problem Gambling Services (A&D 03) in that Program Area whether or not OHA has paid or disbursed to County all financial assistance described in the Financial Assistance Award for local administration of Services in that Program Area; and (b) no further obligation to pay or disburse any financial assistance to County under this Agreement for Services in that Program Area, whether or not OHA has paid or disbursed to County all financial assistance described in the Financial Assistance Award for those Services except: (1) with respect to funds described in the Financial Assistance Award, to the extent OHA's disbursement of financial assistance for a particular Service falling within that Program Area, the financial assistance for which is calculated on a rate per unit of service or service capacity basis, is less than the applicable rate multiplied by the number of applicable units of Service or Service capacity of that type performed or made available during the period from the Effective Date of this Agreement through the termination of County's obligation to include the Program Area, in which that Service falls, in County's CMHP;, and (2) with respect to funds described in the Financial Assistance Award, to the extent OHA's disbursement of financial assistance for a particular Service falling within that Program Area, the financial assistance for which is calculated on a cost reimbursement basis, is less than the cumulative actual Allowable Costs reasonably and necessarily incurred by County with respect to delivery of that Service, during the period from the Effective Date of this Agreement through the termination of County's obligation to include the Program Area, in which that Service falls, in County's CMHP.

(4) Upon termination of County's obligation to include a Program Area in its CMHP, County shall have no further obligation under this Agreement to include that Program Area in its CMHP.

c. Disbursement Limitations. Notwithstanding subsections (a) and (b) above:

(1) Under no circumstances will OHA be obligated to provide financial assistance to County for a particular Service in excess of the amount awarded under this Agreement for that Service as set forth in the Financial Assistance Award; and

(2) Under no circumstances will OHA be obligated to provide financial assistance to County from funds described in the Financial Assistance Award in an amount greater than the amount due County under the Financial Assistance Award for Services, as determined in accordance with the financial assistance calculation methodologies in the applicable Services Descriptions.

d. **Survival.** Exercise of a termination right set forth in the Termination section of this Exhibit or expiration of this Agreement in accordance with its terms, shall not affect County's right to receive financial assistance to which it is entitled hereunder, as described in subsections a. and b. above and as determined through the Agreement Settlement process, or County's right to invoke the dispute resolution processes under Sections 14 and 15 of Exhibit F. Notwithstanding subsections a. and b. above, exercise of the termination rights in Section 8 of this Exhibit or expiration of this Agreement in accordance with its terms, shall not affect County's obligations under this Agreement or OHA's right to enforce this Agreement against County in accordance with its terms, with respect to financial assistance actually disbursed by OHA under this Agreement, or with respect to Services actually delivered. Specifically, but without limiting the generality of the preceding sentence, exercise of a termination right set forth in Section 8 of this Exhibit or expiration of this Agreement in accordance with its terms shall not affect County's representations and warranties, reporting obligations, record-keeping and access obligations, confidentiality obligations, obligation to comply with applicable federal requirements, the restrictions and limitations on County's use of financial assistance actually disbursed by OHA hereunder, County's obligation to cooperate with OHA in the Agreement Settlement process, or OHA's right to recover from County, in accordance with the terms of this Agreement, any financial assistance disbursed by OHA under this Agreement that is identified as an Underexpenditure, Overexpenditure or Misexpenditure. If a termination right set forth in Section 8 of this Exhibit is exercised, both parties shall make reasonable good faith efforts to minimize unnecessary disruption or other problems associated with the termination.

10. **Insurance.** County shall require Providers to maintain insurance as set forth in Exhibit J, "Provider Insurance Requirements," which is attached hereto.

11. **Records Maintenance; Access and Confidentiality.**

a. **Access to Records and Facilities.** OHA, the Secretary of State's Office of the State of Oregon, the Federal Government, and their duly authorized representatives shall have access to the books, documents, papers and records of the County that are directly related to this Agreement, the financial assistance provided hereunder, or any Service for the purpose of making audits, examinations, excerpts, copies and transcriptions. In addition, County shall permit authorized representatives of OHA to perform site reviews of all Services delivered by County.

b. **Retention of Records.** County shall retain and keep accessible all books, documents, papers, and records that are directly related to this Agreement, the financial assistance provided hereunder or any Service, for a minimum of six years, or such longer period as may be required by other provisions of this Agreement or applicable law, following the termination or expiration of this Agreement. If there are unresolved audit or Agreement Settlement questions at the end of the applicable retention period, County shall retain the records until the questions are resolved.

c. **Expenditure Records.** County shall document the use and expenditure of all financial assistance paid by OHA under this Agreement. Unless applicable federal law requires County to utilize a different accounting system, County shall create and maintain all use and expenditure records in accordance with generally accepted accounting principles and in sufficient detail to permit OHA to verify how the financial assistance paid by OHA under this Agreement was used or expended.

d. **Client Records.** If County delivers a Service directly, County shall create and maintain a Client record for each Client who receives that Service, unless the Service Description precludes delivery of the Service on an individual Client basis and reporting of Service commencement and termination information is not required by the Service Description. The Client record shall contain:

(1) Client identification;
(2) Problem assessment;
(3) Treatment, training or care plan;
(4) Medical information when appropriate; and
(5) Progress notes including Service termination summary and current assessment or evaluation instrument as designated by OHA in administrative rules.

County shall retain Client records in accordance with OAR 166-150-0005 through 166-150-0215 (State Archivist). Unless OAR 166-150-0005 through 166-150-0215 requires a longer retention period, Client records must be retained for a minimum of six years from termination or expiration of this Agreement.

e. **Safeguarding of Client Information.** County shall maintain the confidentiality of Client records as required by applicable state and federal law, including without limitation, ORS 179.495 to 179.509 45 CFR Part 205, 42 CFR Part 2, any administrative rule adopted by OHA implementing the foregoing laws, and any written policies made available to County by OHA. County shall create and maintain written policies and procedures related to the disclosure of Client information, and shall make such policies and procedures available to OHA for review and inspection as reasonably requested by OHA.

12. **Information Privacy/Security/Access.** If the Services performed under this Agreement requires County or its Provider(s) to access or otherwise use any OHA Information Asset or Network and Information System to which security and privacy requirements apply, and OHA grants County, its Provider(s), or both access to such OHA Information Assets or Network and Information Systems, County shall comply and require its Provider(s) to which such access has been granted to comply with the terms and conditions applicable to such access or use, including OAR 943-014-0300 through OAR 943-014-0320, as such rules may be revised from time to time. For purposes of this section, "Information Asset" and "Network and Information System" have the meaning set forth in OAR 943-014-0305, as such rule may be revised from time to time.

13. **Force Majeure.** Neither OHA nor County shall be held responsible for delay or default caused by fire, civil unrest, labor unrest, natural causes, or war which is beyond the reasonable control of OHA or County, respectively. 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. Either party may terminate this Agreement upon written notice to the other party after reasonably determining that the delay or default will likely prevent successful performance of this Agreement.

14. **Assignment of Agreement, Successors in Interest.**

a. County shall not assign or transfer its interest in this Agreement without prior written approval of OHA. Any such assignment or transfer, if approved, is subject to such conditions and provisions as OHA may deem necessary. No approval by OHA of any assignment or transfer of interest shall be deemed to create any obligation of OHA in addition to those set forth in this Agreement.

b. The provisions of this Agreement shall be binding upon and shall inure to the benefit of the parties to this Agreement, and their respective successors and permitted assigns.

15. **No Third Party Beneficiaries.** OHA and County are the only parties to this Agreement and are the only parties entitled to enforce its terms. The parties agree that County's performance under this Agreement is solely for the benefit of OHA to assist and enable OHA to accomplish 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.

16. **Amendment.** No amendment, modification or change of terms of this Agreement shall bind either party unless in writing and signed by both parties and when required by the Department of Justice. Such amendment, modification or change, if made, shall be effective only in the specific instance and for the specific purpose given.

17. **Severability.** The parties agree that 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 the Agreement did not contain the particular term or provision held to be invalid.

18. **Notice.** Except as otherwise expressly provided in this Agreement, any communications between the parties hereto or notices to be given hereunder shall be given in writing by personal delivery, facsimile, or mailing the same, postage prepaid to County or OHA at the address or number set forth below, or to such other addresses or numbers as either party may indicate pursuant to this section. Any communication or notice so addressed and mailed shall be effective five calendar days after mailing. Any communication or notice delivered by facsimile shall be effective on the day the transmitting machine generates a receipt of the successful transmission, if transmission was during normal business hours of the recipient, or on the next business day, if transmission was outside normal business hours of the recipient. To be effective against the other party, any notice transmitted by facsimile must be confirmed by telephone notice to the other party at number listed below. Any communication or notice given by personal delivery shall be effective when actually delivered to the addressee.

OHA: Office of Contracts & Procurement
635 Capitol Street NE, Suite 350
Salem, OR 97301
Telephone: 503-945-5818 Facsimile: 503-378-4324

E-mail address: _____

COUNTY: Contact Name: _____
Title: _____
Street Address: _____
City, State Zip: _____

Telephone: _____ Facsimile: _____

E-mail address: _____

19. **Headings.** The headings and captions to sections of this Agreement have been inserted for identification and reference purposes only and shall not be used to construe the meaning or to interpret this Agreement.

20. **Counterparts.** This Agreement and any subsequent amendments may be executed in several counterparts, all of which when taken together shall constitute one agreement binding on all parties, notwithstanding that all parties are not signatories to the same counterpart. Each copy of this Agreement and any amendments so executed shall constitute an original.

21. **Integration and Waiver.** This Agreement, including all Exhibits, constitutes the entire Agreement between the parties on the subject matter hereof. There are no understandings, agreements, or representations, oral or written, not specified herein regarding this Agreement. The failure of either party to enforce any provision of this Agreement shall not constitute a waiver by that party of that or any other provision. No waiver or consent shall be effective unless in writing and signed by the party against whom it is asserted.

22. **Construction.** This Agreement is the product of extensive negotiations between OHA and representatives of county governments. The provisions of this Agreement are to be interpreted and their legal effects determined as a whole. An arbitrator or court interpreting this Agreement shall give a reasonable, lawful and effective meaning to the Agreement to the extent possible, consistent with the public interest.

23. **Contribution.** If any third party makes any claim or brings any action, suit or proceeding alleging a tort as now or hereafter defined in ORS 30.260 ("Third Party Claim") against a party (the "Notified Party") with respect to which the other party ("Other Party") may have liability, the Notified Party must promptly notify the Other Party in writing of the Third Party Claim and deliver to the Other Party a copy of the claim, process, and all legal pleadings with respect to the Third Party Claim. Either party is entitled to participate in the defense of a Third-Party Claim, and to defend a Third-Party Claim with counsel of its own choosing. Receipt by the Other Party of the notice and copies required in this paragraph and meaningful opportunity for the Other Party to participate in the investigation, defense and settlement of the Third-Party Claim with counsel of its own choosing are conditions precedent to the Other Party's liability with respect to the Third-Party Claim.

    With respect to a Third-Party Claim for which the State is jointly liable with the County (or would be if joined in the Third-Party Claim), the State shall contribute to the amount of expenses (including attorneys' fees), judgments, fines and amounts paid in settlement actually and reasonably incurred and paid or payable by the County in such proportion as is appropriate to reflect the relative fault of the State on the one hand and of the County on the other hand in connection with the events which resulted in such expenses, judgments, fines or settlement amounts, as well as any other relevant equitable considerations. The relative fault of the State on the one hand and of the County on the other hand shall be determined by reference to, among other things, the parties' relative intent, knowledge, access to information and opportunity to correct or prevent the circumstances resulting in such expenses, judgments, fines or settlement amounts. The State's contribution amount in any instance is capped to the same extent it would have been capped under Oregon law if the State had sole liability in the proceeding.

With respect to a Third Party Claim for which the County is jointly liable with the State (or would be if joined in the Third Party Claim), the County shall contribute to the amount of expenses (including attorneys' fees), judgments, fines and amounts paid in settlement actually and reasonably incurred and paid or payable by the State in such proportion as is appropriate to reflect the relative fault of the County on the one hand and of the State on the other hand in connection with the events which resulted in such expenses, judgments, fines or settlement amounts, as well as any other relevant equitable considerations. The relative fault of the County on the one hand and of the State on the other hand shall be determined by reference to, among other things, the parties' relative intent, knowledge, access to information and opportunity to correct or prevent the circumstances resulting in such expenses, judgments, fines or settlement amounts. The County's contribution amount in any instance is capped to the same extent it would have been capped under Oregon law if it had sole liability in the proceeding.

24. **Indemnification by Providers.** County shall take all reasonable steps to cause its Provider(s) that are not units of local government as defined in ORS 190.003, if any, to indemnify, defend, save and hold harmless the State of Oregon and its officers, employees and agents ("Indemnitee") from and against any and all claims, actions, liabilities, damages, losses, or expenses (including attorneys' fees) arising from a tort (as now or hereafter defined in ORS 30.260) caused, or alleged to be caused, in whole or in part, by the negligent or willful acts or omissions of County's Provider or any of the officers, agents, employees or subcontractors of the contractor("Claims"). It is the specific intention of the parties that the Indemnitee shall, in all instances, except for Claims arising solely from the negligent or willful acts or omissions of the Indemnitee, be indemnified by the contractor from and against any and all Claims.

2021 INTERGOVERNMENTAL AGREEMENT
FOR THE FINANCING OF COMMUNITY MENTAL HEALTH, ADDICTION TREATMENT, RECOVERY, & PREVENTION, AND PROBLEM GAMBLING SERVICES

EXHIBIT H
REQUIRED FEDERAL TERMS AND CONDITIONS

In addition to the requirements of section 2 of Exhibit G, County shall comply, and as indicated, require all Providers to comply with the following federal requirements when federal funding is being used. For purposes of this Agreement, all references to federal and state laws are references to federal and state laws as they may be amended from time to time.

1. **Miscellaneous Federal Provisions.** County shall comply and require all Providers to comply with all federal laws, regulations, and executive orders applicable to the Agreement or to the delivery of Services. Without limiting the generality of the foregoing, County expressly agrees to comply and require all Providers to comply with the following laws, regulations and executive orders to the extent they are applicable to the Agreement: (a) Title VI and VII of the Civil Rights Act of 1964, as amended, (b) Sections 503 and 504 of the Rehabilitation Act of 1973, as amended, (c) the Americans with Disabilities Act of 1990, as amended, (d) Executive Order 11246, as amended, (e) the Health Insurance Portability and Accountability Act of 1996, as amended, (f) the Age Discrimination in Employment Act of 1967, as amended, and the Age Discrimination Act of 1975, as amended, (g) the Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended, (h) all regulations and administrative rules established pursuant to the foregoing laws, (i) all other applicable requirements of federal civil rights and rehabilitation statutes, rules and regulations, and (j) all federal law governing operation of Community Mental Health Programs, including without limitation, all federal laws requiring reporting of Client abuse. These laws, regulations and executive orders are incorporated by reference herein to the extent that they are applicable to the Agreement and required by law to be so incorporated. No federal funds may be used to provide Services in violation of 42 U.S.C. 14402.

2. **Equal Employment Opportunity.** If this Agreement, including amendments, is for more than $10,000, then County shall comply and require all Providers to comply with Executive Order 11246, entitled "Equal Employment Opportunity," as amended by Executive Order 11375, and as supplemented in U.S. Department of Labor regulations (41 CFR Part 60).

3. **Clean Air, Clean Water, EPA Regulations.** If this Agreement, including amendments, exceeds $100,000 then County shall comply and require all Providers to comply with all applicable standards, orders, or requirements issued under Section 306 of the Clean Air Act (42 U.S.C. 7606), the Federal Water Pollution Control Act as amended (commonly known as the Clean Water Act) (33 U.S.C. 1251 to 1387), specifically including, but not limited to Section 508 (33 U.S.C. 1368), Executive Order 11738, and Environmental Protection Agency regulations (2 CFR Part 1532), which prohibit the use under non-exempt Federal contracts, grants or loans of facilities included on the EPA List of Violating Facilities. Violations shall be reported to OHA, United States Department of Health and Human Services and the appropriate Regional Office of the Environmental Protection Agency. County shall include and require all Providers to include in all contracts with subcontractors receiving more than $100,000, language requiring the subcontractor to comply with the federal laws identified in this section.

4. **Energy Efficiency.** County shall comply and require all Providers to comply with applicable mandatory standards and policies relating to energy efficiency that are contained in the Oregon energy conservation plan issued in compliance with the Energy Policy and Conservation Act 42 U.S.C. 6201 et. seq. (Pub. L. 94-163).

5. **Truth in Lobbying.** By signing this Agreement, the County certifies, to the best of the County's knowledge and belief that:

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

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

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

   d. This certification is a material representation of fact upon which reliance was placed when this Agreement was made or entered into. Submission of this certification is a prerequisite for making or entering into this Agreement imposed by section 1352, Title 31 of the U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

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

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

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

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

6. **Resource Conservation and Recovery.** County shall comply and require all Providers to comply with all mandatory standards and policies that relate to resource conservation and recovery pursuant to the Resource Conservation and Recovery Act (codified at 42 U.S.C. 6901 et. seq.). Section 6002 of that Act (codified at 42 U.S.C. 6962) requires that preference be given in procurement programs to the purchase of specific products containing recycled materials identified in guidelines developed by the Environmental Protection Agency. Current guidelines are set forth in 40 CFR Part 247.

7. **Audits.** Sub recipients, as defined in 45 CFR 75.2, which includes, but is not limited to County, shall comply, and County shall require all Providers to comply, with applicable Code of Federal Regulations (CFR) governing expenditure of federal funds including, but not limited to, if a sub-recipient expends $500,000 or more in Federal funds (from all sources) in its fiscal year beginning prior to December 26, 2014, a sub-recipient shall have a single organization-wide audit conducted in accordance with the Single Audit Act. If a sub-recipient expends $750,000 or more in federal funds (from all sources) in a fiscal year beginning on or after December 26, 2014, it shall have a single organization-wide audit conducted in accordance with the provisions of 45 CFR part 75, subpart F. Copies of all audits must be submitted to OHA within 30 calendar days of completion. If a sub recipient expends less than $500,000 in Federal funds in a fiscal year beginning prior to December 26, 2014, or less than $750,000 in a fiscal year beginning on or after that date, it is exempt from Federal audit requirements for that year. Records must be available for review or audit by appropriate officials.

8. **Debarment and Suspension.** County shall not permit any person or entity to be a Provider if the person or entity is listed on the non-procurement portion of the General Service Administration's "List of Parties Excluded from Federal Procurement or Non-procurement Programs" in accordance with Executive Orders No. 12549 and No. 12689, "Debarment and Suspension". (See 2 CFR Part 180). This list contains the names of parties debarred, suspended, or otherwise excluded by agencies, and contractors declared ineligible under statutory authority other than Executive Order No. 12549. Providers with awards that exceed the simplified acquisition threshold shall provide the required certification regarding their exclusion status and that of their principals prior to award.

9. **Drug-Free Workplace.** County shall comply and require all Providers to comply with the following provisions to maintain a drug-free workplace: (i) County certifies that it will provide a drug-free workplace by publishing a statement notifying its employees that the unlawful manufacture, distribution, dispensation, possession or use of a controlled substance, except as may be present in lawfully prescribed or over-the-counter medications, is prohibited in County's workplace or while providing Services to OHA clients. County's notice shall specify the actions that will be taken by County against its employees for violation of such prohibitions; (ii) Establish a drug-free awareness program to inform its employees about: The dangers of drug abuse in the workplace, County's policy of maintaining a drug-free workplace, any available drug counseling, rehabilitation, and employee assistance programs, and the penalties that may be imposed upon employees for drug abuse violations; (iii) Provide each employee to be engaged in the performance of Services under this Agreement a copy of the statement mentioned in paragraph (i) above; (iv) Notify each employee in the statement required by paragraph (i) above that, as a condition of employment to provide services under this Agreement, the employee will: abide by the terms of the statement, and notify the employer of any criminal drug statute conviction for a violation occurring in the workplace no later than five (5) calendar days after such conviction; (v) Notify OHA within ten (10) calendar days after receiving notice under subparagraph (iv) above from an employee or otherwise receiving actual notice of such conviction; (vi) Impose a sanction on, or require the satisfactory participation in a drug abuse assistance or rehabilitation program by any employee who is so convicted as required by Section 5154 of the Drug-Free Workplace Act of 1988; (vii) Make a good-faith effort to continue a drug-free workplace through implementation of subparagraphs (i) through (vi) above; (viii) Require any Provider to comply with subparagraphs (i) through (vii) above; (ix) Neither County, or any of County's employees, officers, agents or Providers may provide any Service required under this Agreement while under the influence of drugs. For purposes of this provision, "under the influence" means: observed abnormal behavior or impairments in mental or physical performance leading a reasonable person to believe the County or County's employee, officer, agent or Provider has used a controlled substance, prescription or non-prescription medication that impairs the County or County's employee, officer, agent or Provider's performance of essential job function or creates a direct threat to OHA clients or others. Examples of abnormal behavior include, but are not limited to: hallucinations, paranoia or violent outbursts. Examples of impairments in physical or mental performance include, but are not limited to: slurred speech, difficulty walking or performing job activities; and (x) Violation of any provision of this subsection may result in termination of this Agreement.

10. **Pro-Children Act.** County shall comply and require all Providers to comply with the Pro-Children Act of 1994 (codified at 20 U.S.C. Section 6081 et. seq.).

11. **Medicaid Services.** To the extent County provides any Service in which costs are paid in whole or in part by Medicaid, County shall comply with all applicable federal and state laws and regulation pertaining to the provision of Medicaid Services under the Medicaid Act, Title XIX, 42 U.S.C. Section 1396 et. seq., including without limitation:

    a. Keep such records as are necessary to fully disclose the extent of the services provided to Individuals receiving Medicaid assistance and shall furnish such information to any state or federal agency responsible for administering the Medicaid program regarding any payments claimed by such person or institution for providing Medicaid Services as the state or federal agency may from time to time request. 42 U.S.C. Section 1396a (a) (27); 42 CFR Part 431.107(b)(1) & (2).

    b. Comply with all disclosure requirements of 42 CFR Part 1002.3(a) and 42 CFR 455 Subpart (B).

c. Maintain written notices and procedures respecting advance directives in compliance with 42 U.S.C. Section 1396 (a) (57) and (w), 42 CFR Part 431.107 (b) (4), and 42 CFR Part 489 subpart I.

d. Certify when submitting any claim for the provision of Medicaid Services that the information submitted is true, accurate and complete. County shall acknowledge County's understanding that payment of the claim will be from federal and state funds and that any falsification or concealment of a material fact may be prosecuted under federal and state laws.

e. Entities receiving $5 million or more annually (under this Agreement and any other Medicaid agreement) for furnishing Medicaid health care items or services shall, as a condition of receiving such payments, adopt written fraud, waste and abuse policies and procedures and inform employees, Providers and agents about the policies and procedures in compliance with Section 6032 of the Deficit Reduction Act of 2005, 42 U.S.C. § 1396a (a) (68).

12. **ADA.** County shall comply with Title II of the Americans with Disabilities Act of 1990 (codified at 42 U.S.C. 12131 et. seq.) in the construction, remodeling, maintenance and operation of any structures and facilities, and in the conduct of all programs, services and training associated with the delivery of Services.

13. **Agency-Based Voter Registration.** If applicable, County shall comply with the Agency-based Voter Registration sections of the National Voter Registration Act of 1993 that require voter registration opportunities be offered where an Individual may apply for or receive an application for public assistance.

14. **Disclosure.**

a. 42 CFR 455.104 requires the State Medicaid agency to obtain the following information from any provider of Medicaid or CHIP services, including fiscal agents of providers and managed care entities: (1) the name and address (including the primary business address, every business location and P.O. Box address) of any person (Individual or corporation) with an ownership or control interest in the provider, fiscal agent or managed care entity; (2) in the case of an Individual, the date of birth and Social Security Number, or, in the case of a corporation, the tax identification number of the entity, with an ownership interest in the provider, fiscal agent or managed care entity or of any subcontractor in which the provider, fiscal agent or managed care entity has a 5% or more interest; (3) whether the person (Individual or corporation) with an ownership or control interest in the provider, fiscal agent or managed care entity is related to another person with ownership or control interest in the provider, fiscal agent or managed care entity as a spouse, parent, child or sibling, or whether the person (Individual or corporation) with an ownership or control interest in any subcontractor in which the provider, fiscal agent or managed care entity has a 5% or more interest is related to another person with ownership or control interest in the provider, fiscal agent or managed care entity as a spouse, parent, child or sibling; (4) the name of any other provider, fiscal agent or managed care entity in which an owner of the provider, fiscal agent or managed care entity has an ownership or control interest; and, (5) the name, address, date of birth and Social Security Number of any managing employee of the provider, fiscal agent or managed care entity.

b. 42 CFR 455.434 requires as a condition of enrollment as a Medicaid or CHIP provider, to consent to criminal background checks, including fingerprinting when required to do so under state law, or by the category of the provider based on risk of fraud, waste and abuse under federal law. As such, a provider must disclose any person with a 5% or greater direct or indirect ownership interest in the provider whom has been convicted of a criminal offense related to that person's involvement with the Medicare, Medicaid, or title XXI program in the last 10 years.

c. OHA reserves the right to take such action required by law, or where OHA has discretion, it deems appropriate, based on the information received (or the failure to receive) from the provider, fiscal agent or managed care entity.

15. Special Federal Requirements Applicable to Addiction Treatment, Recovery, & Prevention Services for Counties receiving Substance Abuse Prevention and Treatment (SAPT) Block Grant funds.

a. Order for Admissions:

(1) Pregnant women who inject drugs;

(2) Pregnant substance abusers;

(3) Other Individuals who inject drugs; and

(4) All others.

b. Women's or Parent's Services. If County provides A&D 61 and A&D 62 Services, County must:

(1) Treat the family as a unit and admit both women or parent and their children if appropriate.

(2) Provide or arrange for the following services to pregnant women and women with dependent children:

(a) Primary medical care, including referral for prenatal care;

(b) Pediatric care, including immunizations, for their children;

(c) Gender-specific treatment and other therapeutic interventions, e.g. sexual and physical abuse counseling, parenting training, and child care;

(d) Therapeutic interventions for children in custody of women or parent in treatment, which address, but are not limited to, the children's developmental needs and issues of abuse and neglect; and

(e) Appropriate case management services and transportation to ensure that women or parents and their children have access to the services in (a) through (d) above.

c. Pregnant Women. If County provides any Addiction Treatment, Recovery, & Prevention Services other than A&D 84, Problem Gambling, Client Finding Outreach Services, County must:

(1) Within the priority categories, if any, set forth in a particular Service Description, give preference in admission to pregnant women in need of treatment, who seek or are referred for and would benefit from such Services, within 48 hours;

(2) If County has insufficient capacity to provide treatment Services to a pregnant woman, County must refer the women to another Provider with capacity or if no available treatment capacity can be located, the outpatient Provider that the Individual is enrolled with will ensure that Interim Services are being offered. Counseling on the effects of alcohol and drug use on the fetus must be given within 48 hours, including a referral for prenatal care; and

(3) Perform outreach to inform pregnant women of the availability of treatment Services targeted to them and the fact that pregnant women receive preference in admission to these programs.

d. **Intravenous Drug Abusers.** If County provides any Addiction Treatment, Recovery, & Prevention Services, other than A&D 84 Problem Gambling, Client Finding Outreach Services, County must:

(1) Within the priority categories, if any, set forth in a particular Service Description and subject to the preference for pregnant women described above, give preference in admission to intravenous drug abusers;

(2) Programs that receive funding under the grant and that treat Individuals for intravenous substance abuse, upon reaching 90 percent of its capacity to admit Individuals to the program, must provide notification of that fact to the State within 7 calendar days;

(3) If County receives a request for admission to treatment from an intravenous drug abuser, County must, unless it succeeds in referring the Individual to another Provider with treatment capacity, admit the Individual to treatment not later than:

(a) 14 calendar days after the request for admission to County is made;

(b) 120 calendar days after the date of such request if no Provider has the capacity to admit the Individual on the date of such request and, if Interim Services are made available not less than 48 hours after such request; or

(c) If County has insufficient capacity to provide treatment Services to an intravenous drug abuser, refer the intravenous drug abuser to another Provider with capacity or if no available treatment capacity can be located, the outpatient provider that the Individual is enrolled with will ensure that interim services are being offered. If the Individual is not enrolled in outpatient treatment and is on a waitlist for residential treatment, the provider from the county of the Individual's residence that is referring the Individual to residential services will make available counseling and education about human immunodeficiency virus (HIV) and tuberculosis(TB), risk of sharing needles, risks of transmission to sexual partners and infant, steps to ensure HIV and TB transmission does not occur, referral for HIV or TB treatment services, if necessary, within 48 hours.

e. **Infectious Diseases.** If County provides any Addiction Treatment, Recovery, & Prevention Services, other than A&D 84 Problem Gambling, Client Finding Outreach Services, County must:

(1) Complete a risk assessment for infectious disease including Human Immunodeficiency Virus (HIV) and tuberculosis, as well as sexually transmitted

diseases, based on protocols established by OHA, for every Individual seeking Services from County; and

(2) Routinely make tuberculosis services available to each Individual receiving Services for alcohol/drug abuse either directly or through other arrangements with public or non-profit entities and, if County denies an Individual admission on the basis of lack of capacity, refer the Individual to another provider of tuberculosis Services.

(3) For purposes of (2) above, "tuberculosis services" means:

(a) Counseling the Individual with respect to tuberculosis;

(b) Testing to determine whether the Individual has contracted such disease and testing to determine the form of treatment for the disease that is appropriate for the Individual; and

(c) Appropriate treatment services.

f. **OHA Referrals.** If County provides any Addiction Treatment, Recovery, & Prevention Services, other than A&D 84 Problem Gambling, Client Finding Outreach Services, County must, within the priority categories, if any, set forth in a particular Service Description and subject to the preference for pregnant women and intravenous drug users described above, give preference in Addiction Treatment, Recovery, & Prevention and Problem Gambling Service delivery to persons referred by OHA.

g. **Barriers to Treatment.** Where there is a barrier to delivery of any Addiction Treatment, Recovery, & Prevention, and Problem Gambling Service due to culture, gender, language, illiteracy, or disability, County shall develop support services available to address or overcome the barrier, including:

(1) Providing, if needed, hearing impaired or foreign language interpreters.

(2) Providing translation of written materials to appropriate language or method of communication (except as provided in Exhibit F, "General Terms and Conditions," Section 7., "Alternative Formats and Translation of Written Materials, Interpreter Services").

(3) Providing devices that assist in minimizing the impact of the barrier.

(4) Not charging clients for the costs of measures, such as interpreters, that are required to provide nondiscriminatory treatment.

h. **Misrepresentation.** County shall not knowingly or willfully make or cause to be made any false statement or representation of a material fact in connection with the furnishing of items or Services for which payments may be made by OHA.

i. **Oregon Residency.** Addiction Treatment, Recovery, & Prevention, and Problem Gambling Services funded through this Agreement may only be provided to residents of Oregon. Residents of Oregon are Individuals who live in Oregon. There is no minimum amount of time an Individual must live in Oregon to qualify as a resident so long as the Individual intends to remain in Oregon. A child's residence is not dependent on the residence of his or her parents. A child living in Oregon may meet the residency requirement if the caretaker relative with whom the child is living is an Oregon resident. **j.** **Tobacco Use.** If County has Addiction Treatment, Recovery, & Prevention Services treatment capacity that has been designated for children, adolescents, pregnant women, and women with dependent children, County must implement a policy to

eliminate smoking and other use of tobacco at the facilities where the Services are delivered and on the grounds of such facilities.

k. **Client Authorization.** County must comply with 42 CFR Part 2 when delivering an Addiction Treatment, Recovery, & Prevention Service that includes disclosure of Client information for purposes of eligibility determination. County must obtain Client authorization for disclosure of billing information, to the extent and in the manner required by 42 CFR Part 2, before a Disbursement Claim is submitted with respect to delivery of an Addiction Treatment, Recovery, & Prevention Service to that Individual.

16. **Special Federal Requirements Applicable To Addiction Treatment, Recovery, & Prevention Services for Counties Receiving Temporary Assistance for Needy Families (TANF) Grant Funds.**

Funding requirements. TANF may only be used for families receiving TANF, and for families at risk of receiving TANF, and for the purpose of providing housing services (room and board) for Individuals who are dependent children ages 18 years old or younger whose parent is in adult addiction residential treatment, so that the children may reside with their parent in the same treatment facility. Families at-risk of receiving TANF must:

a. Include a dependent child age 18 years of age or under, who is living with a parent or caretaker relative. "Caretaker relative" means a blood relative of the child; stepmother, stepfather, stepbrother, or stepsister; or an individual who has legally adopted the child.

b. Be an Oregon resident.

c. Have income at or below 250% of the Federal Poverty Level.

Use of TANF block grant funds and state expenditures counted towards TANF MOE must meet the requirements of 45 CFR Part 263. Only non-medical Services may be provided with TANF Block Grant funds.

17. **Community Mental Health Block Grant.** All funds, if any, awarded under this Agreement for Community Mental Health Services are subject to the federal use restrictions and requirements set forth in Catalog of Federal Domestic Assistance Number 93.958 and to the federal statutory and regulatory restrictions imposed by or pursuant to the Community Mental Health Block Grant portion of the Public Health Services Act, 42 U.S.C. 300x-1 *et. seq.,* and County shall comply with those restrictions.

18. **Substance Abuse Prevention and Treatment.** To the extent County provides any Service in which costs are paid in whole or in part by the Substance Abuse, Prevention, and Treatment Block Grant, County shall comply with federal rules and statutes pertaining to the Substance Abuse, Prevention, and Treatment Block Grant, including the reporting provisions of the Public Health Services Act (42 U.S.C. 300x through 300x-66) and 45 CFR 96.130 regarding the sale of tobacco products. Regardless of funding source, to the extent County provides any substance abuse prevention or treatment services, County shall comply with the confidentiality requirements of 42 CFR Part 2. CMHP may not use the funds received under this Agreement for inherently religious activities, as described in 45 CFR Part 87.

19. **Information Required by 2 CFR Subtitle B with guidance at 2 CFR Part 200.** All required data elements in accordance with 45 CFR 75.352 are available at: http://www.oregon.gov/oha/hsd/amh/Pages/federal-reporting.aspx.

20. **Super Circular Requirements.** 2 CFR Part 200, or the equivalent applicable provision adopted by the awarding federal agency in 2 CFR Subtitle B, including but not limited to the following:

a. **Property Standards**. 2 CFR 200.313, or the equivalent applicable provision adopted by the awarding federal agency in 2 CFR Subtitle B, which generally describes the required maintenance, documentation, and allowed disposition of equipment purchased with federal funds.

b. **Procurement Standards**. When procuring goods or services (including professional consulting services), applicable state procurement regulations found in the Oregon Public Contracting Code, ORS chapters 279A, 279B and 279C or 2 CFR §§ 200.318 through 200.326, or the equivalent applicable provision adopted by the awarding federal agency in 2 CFR Subtitle B, as applicable.

c. **Contract Provisions.** The contract provisions listed in 2 CFR Part 200, Appendix II, or the equivalent applicable provision adopted by the awarding federal agency in 2 CFR Subtitle B, that are hereby incorporated into this Exhibit, are, to the extent applicable, obligations of Recipient, and Recipient shall also include these contract provisions in its contracts with non-Federal entities.

2021 INTERGOVERNMENTAL AGREEMENT
FOR THE FINANCING OF COMMUNITY MENTAL HEALTH, ADDICTION TREATMENT, RECOVERY, & PREVENTION, AND PROBLEM GAMBLING SERVICES

EXHIBIT I
REQUIRED PROVIDER CONTRACT PROVISIONS

1. **Expenditure of Funds.** Provider may expend the funds paid to Provider under this Contract solely on the delivery of _____, subject to the following limitations (in addition to any other restrictions or limitations imposed by this Contract):

   a. Provider may not expend on the delivery of _____ any funds paid to Provider under this Contract in excess of the amount reasonable and necessary to provide quality delivery of _____.

   b. If this Contract requires Provider to deliver more than one service, Provider may not expend funds paid to Provider under this Contract for a particular service on the delivery of any other service.

   c. If this Contract requires Provider to deliver Addiction Treatment, Recovery, & Prevention, and Problem Gambling Services, Provider may not use the funds paid to Provider under this Contract for such services to:

      (1) Provide inpatient hospital services;

      (2) Make cash payments to intended recipients of health services;

      (3) Purchase or improve land, to purchase, construct or permanently improve (other than minor remodeling) any building or other facility or to purchase major medical equipment;

      (4) Satisfy any requirement for expenditure of non-federal funds as a condition for receipt of federal funds (whether the federal funds are received under this Contract or otherwise); or

      (5) Carry out any program prohibited by section 245(b) of the Health Omnibus Programs Extension Act of 1988 (codified at 42 U.S.C. 300ee-5), which generally prohibits funds provided under this Agreement from being used to provide Individuals with hypodermic needles or syringes so that such Individuals may use illegal drugs, unless the Surgeon General of the Public Health Service determines that a demonstration needle exchange program would be effective in reducing drug abuse.

   d. Provider may expend funds paid to Provider under this Contract only in accordance with OMB Circulars or 45 CFR Part 75, as applicable on Allowable Costs. If Provider receives $500,000 or more in Federal funds (from all sources) in its fiscal year beginning prior to December 26, 2014, it shall have a single organization-wide audit conducted in accordance with the Single Audit Act. If Provider expends $750,000 or more in federal funds (from all sources) in a fiscal year beginning on or after December 26, 2014, it shall have a single organization-wide audit conducted in accordance with the provisions of 45 CFR part 75, subpart F. If Provider expends less than $500,000 in Federal funds in a fiscal year beginning prior to December 26, 2014, or less than $750,000 in a fiscal year beginning on or after that date, it is exempt from Federal audit requirements for that year. Records must be available for review or audit by appropriate officials. Provider, if subject to this

requirement, shall at Provider's own expense submit to OHA a copy of, or electronic link to, its annual audit subject to this requirement covering the funds expended under this Agreement and shall submit or cause to be submitted to OHA the annual audit of any subrecipient(s), contractor(s), or subcontractor(s) of Provider responsible for the financial management of funds received under this Agreement. Copies of all audits must be submitted to OHA within 30 calendar days of completion. Audit costs for audits not required in accordance with the Single Audit Act are unallowable. Provider may not use the funds received under this Agreement for inherently religious activities, as described in 45 CFR Part 87.

2. **Records Maintenance, Access and Confidentiality**.

a. **Access to Records and Facilities**. County, the Oregon Health Authority, the Secretary of State's Office of the State of Oregon, the Federal Government, and their duly authorized representatives shall have access to the books, documents, papers and records of Provider that are directly related to this Contract, the funds paid to Provider hereunder, or any services delivered hereunder for the purpose of making audits, examinations, excerpts, copies and transcriptions. In addition, Provider shall permit authorized representatives of County and the Oregon Health Authority to perform site reviews of all services delivered by Provider hereunder.

b. **Retention of Records.** Provider shall retain and keep accessible all books, documents, papers, and records, that are directly related to this Contract, the funds paid to Provider hereunder or to any services delivered hereunder, for a minimum of 6 years, or such longer period as may be required by other provisions of this Contract or applicable law, following the termination or expiration of this Contract. If there are unresolved audit or other questions at the end of the six-year period, Provider shall retain the records until the questions are resolved.

c. **Expenditure Records.** Provider shall document the expenditure of all funds paid to Provider under this Contract. Unless applicable federal law requires Provider to utilize a different accounting system, Provider shall create and maintain all expenditure records in accordance with generally accepted accounting principles and in sufficient detail to permit County and the Oregon Health Authority to verify how the funds paid to Provider under this Contract were expended.

d. **Client Records.** Unless otherwise specified in this Contract, Provider shall create and maintain a client record for each client who receives services under this Contract. The client record must contain:

(1) Client identification;

(2) Problem assessment;

(3) Treatment, training and/or care plan;

(4) Medical information when appropriate; and

(5) Progress notes including service termination summary and current assessment or evaluation instrument as designated by the Oregon Health Authority in administrative rules.

Provider shall retain client records in accordance with OAR 166-150-0005 through 166-150-0215 (State Archivist). Unless OAR 166-150-0005 through 166-150-0215 requires a longer retention period, client records must be retained for a minimum of six years from termination or expiration of this contract.

e. **Safeguarding of Client Information.** Provider shall maintain the confidentiality of client records as required by applicable state and federal law, including without limitation, ORS 179.495 to 179.507, 45 CFR Part 205, 42 CFR Part 2, any administrative rule adopted by the Oregon Health Authority, implementing the foregoing laws, and any written policies made available to Provider by County or by the Oregon Health Authority. Provider shall create and maintain written policies and procedures related to the disclosure of client information, and shall make such policies and procedures available to County and the Oregon Health Authority for review and inspection as reasonably requested by County or the Oregon Health Authority.

f. **Data Reporting.**

All Individuals receiving Services with funds provided under this Contract must be enrolled and that Individual's record maintained in the Measures and Outcome Tracking System (MOTS) as specified in OHA's MOTS Reference Manual located at: http://www.oregon.gov/oha/hsd/amh-mots/Pages/index.aspx, and the "Who Reports in MOTS Policy" as follows:

Which Behavioral Health Providers are Required to Report in MOTS?

The data collection system for the Health Systems Division (HSD) is the Measures and Outcomes Tracking System or MOTS. In general, behavioral health providers who are either licensed or have a letter of approval from the HSD (or the former Addictions & Mental Health Division [AMH]), and receive public funds to provide treatment services are required to report to MOTS. In addition to the general rule above, there are four basic ways to classify who is required to submit data to MOTS:

(1) Providers with HSD contracts that deliver treatment services (this includes Community Mental Health Programs [CMHP], Local Mental Health Authorities [LMHA] and other types of community behavioral health providers); these programs should all have a license or letter of approval from the HSD or AMH;

(2) Providers that are subcontractors (can be a subcontractor of a CMHP or other entity that holds a contract with HSD or OHA, such as a Mental Health Organization [MHO], or a Coordinated Care Organization [CCO]);

(3) Providers that HSD does not contract with but are required to submit data to MOTS by State/Federal statute or rule; these include DUII providers and methadone maintenance providers; and

(4) Providers that contract with other governmental agencies (e.g., Oregon Youth Authority [OYA] or the Department of Corrections [DOC] to deliver mental health and/or substance abuse services).

Note: Primary care physicians that provide a single service on behalf of the CMHP are not required to report the MOTS status or service level data.

If there are any questions, contact MOTS Support at MOTS.Support@state.or.us.

3. Alternative Formats of Written Materials, Interpreter Services.

In connection with the delivery of Program Element Services, Provider shall make available to Client, without charge, upon the Client's reasonable request:

a. All written materials related to the services provided to the Client in alternate formats.

b. All written materials related to the services provided to the Client in the Client's language.

c. Oral interpretation services related to the services provided to the Client in the Client's language.

d. Sign language interpretation services and telephone communications access services related to the services provided to the Client.

For purposes of the foregoing, "written materials" means materials created by Provider, in connection with the Service being provided to the requestor. The Provider may develop its own forms and materials and with such forms and materials the Provider shall be responsible for making them available to a Client, without charge to the Client in the prevalent non-English language(s) within the County service area. OHA shall be responsible for making its forms and materials available, without charge to the Client or Provider, in the prevalent non-English language(s) within the Providers service area.

4. **Reporting Requirements.** Provider shall prepare and furnish the following information to County and the Oregon Health Authority when a service is delivered under this Contract:

a. Client, service and financial information as specified in the applicable Service Description attached hereto and incorporated herein by this reference.

b. All additional information and reports that County or the Oregon Health Authority reasonably requests, including, but not limited to, the information or disclosure described in Exhibit H, Required Federal Terms and Conditions, Section 14. Disclosure.

5. **Compliance with Law.** Provider shall comply with all state and local laws, regulations, executive orders and ordinances applicable to the Contract or to the delivery of services hereunder. Without limiting the generality of the foregoing, Provider expressly agrees to comply with the following laws, regulations and executive orders to the extent they are applicable to the Contract: (a) all applicable requirements of state civil rights and rehabilitation statutes, rules and regulations; (b) all state laws governing operation of community mental health programs, including without limitation, all administrative rules adopted by the Oregon Health Authority related to community mental health programs or related to client rights, OAR 943-005-0000 through 943-005-0070, prohibiting discrimination against Individuals with disabilities; (c) all state laws requiring reporting of client abuse; and (d) ORS 659A.400 to 659A.409, ORS 659A.145 and all regulations and administrative rules established pursuant to those laws in the construction, remodeling, maintenance and operation of any structures and facilities, and in the conduct of all programs, services and training associated with the delivery of services under this Contract. These laws, regulations and executive orders are incorporated by reference herein to the extent that they are applicable to the Contract and required by law to be so incorporated. All employers, including Provider, that employ subject workers who provide services in the State of Oregon shall comply with ORS 656.017 and provide the required Workers' Compensation coverage, unless such employers are exempt under ORS 656.126. In addition, Provider shall comply, as if it were County thereunder, with the federal requirements set forth in Exhibit H "Required Federal Terms and Conditions," to the certain 2019-2021 Intergovernmental Agreement for the Financing of Community Mental Health, Addiction Treatment, Recovery, & Prevention, and Problem Gambling Services between County and the Oregon Health Authority dated as of _____, which Exhibit is incorporated herein by this reference. For purposes of this Contract, all references in this Contract to federal and state laws are references to federal and state laws as they may be amended from time to time.

6. Unless Provider is a State of Oregon governmental agency, Provider agrees that it is an independent contractor and not an agent of the State of Oregon, the Oregon Health Authority or County.

7. To the extent permitted by applicable law, Provider shall defend (in the case of the state of Oregon and the Oregon Health Authority, subject to ORS Chapter 180), save and hold harmless the State of Oregon, the Oregon Health Authority, County, and their officers, employees, and agents from and against all claims, suits, actions, losses, damages, liabilities, costs and expenses of any nature whatsoever resulting from, arising out of or relating to the operations of the Provider, including but not limited to the activities of Provider or its officers, employees, subcontractors or agents under this Contract.

8. Provider understands that Provider may be prosecuted under applicable federal and state criminal and civil laws for submitting false claims, concealing material facts, misrepresentation, falsifying data system input, other acts of misrepresentation, or conspiracy to engage therein.

9. Provider shall only conduct transactions that are authorized by the County for transactions with the Oregon Health Authority that involve County funds directly related to this Contract.

10. First tier Provider(s) that are not units of local government as defined in ORS 190.003 shall obtain, at Provider's expense, and maintain in effect with respect to all occurrences taking place during the term of the contract, insurance requirements as specified in Exhibit J "Provider Insurance Requirements," of the certain 2019-2021 Intergovernmental Agreement for the Financing of Community Mental Health, Addiction Treatment, Recovery, & Prevention, and Problem Gambling Services between County and the Oregon Health Authority dated as of _____, which Exhibit is incorporated herein by this reference.

11. Provider(s) that are not units of local government as defined in ORS 190.003, shall indemnify, defend, save and hold harmless the State of Oregon and its officers, employees and agents ("Indemnitee") from and against any and all claims, actions, liabilities, damages, losses, or expenses (including attorneys' fees) arising from a tort (as now or hereafter defined in ORS 30.260) caused, or alleged to be caused, in whole or in part, by the negligent or willful acts or omissions of Provider or any of the officers, agents, employees or subcontractors of the contractor ("Claims"). It is the specific intention of the parties that the Indemnitee shall, in all instances, except for Claims arising solely from the negligent or willful acts or omissions of the Indemnitee, be indemnified by the Provider from and against any and all Claims.

12. Provider shall include sections 1 through 11, in substantially the form set forth above, in all permitted Provider Contracts under this Agreement.

2021 INTERGOVERNMENTAL AGREEMENT
FOR THE FINANCING OF COMMUNITY MENTAL HEALTH, ADDICTION TREATMENT, RECOVERY, & PREVENTION, AND PROBLEM GAMBLING SERVICES

EXHIBIT J
PROVIDER INSURANCE REQUIREMENTS

County shall require its first tier Providers(s) that are not units of local government as defined in ORS 190.003, if any, to: i) obtain insurance specified under TYPES AND AMOUNTS and meeting the requirements under ADDITIONAL INSURED, "TAIL" COVERAGE, NOTICE OF CANCELLATION OR CHANGE, and CERTIFICATES OF INSURANCE before the Providers perform under contracts between County and the Providers (the "Provider Contracts"); and ii) maintain the insurance in full force throughout the duration of the Provider Contracts. The insurance must be provided by insurance companies or entities that are authorized to transact the business of insurance and issue coverage in the State of Oregon and that are acceptable to OHA. County shall not authorize Providers to begin work under the Provider Contracts until the insurance is in full force. Thereafter, County shall monitor continued compliance with the insurance requirements on an annual or more frequent basis. County shall incorporate appropriate provisions in the Provider Contracts permitting it to enforce Provider compliance with the insurance requirements and shall take all reasonable steps to enforce such compliance. Examples of "reasonable steps" include issuing stop work orders (or the equivalent) until the insurance is in full force or terminating the Provider Contracts as permitted by the Provider Contracts, or pursuing legal action to enforce the insurance requirements. In no event shall County permit a Provider to work under a Provider Contract when the County is aware that the Provider is not in compliance with the insurance requirements. As used in this section, a "first tier" Provider is a Provider with whom the County directly enters into a Provider Contract. It does not include a subcontractor with whom the Provider enters into a contract.

TYPES AND AMOUNTS.

1. **Workers Compensation:** Must be in compliance with ORS 656.017, which requires all employers that employ subject workers, as defined in ORS 656.027, to provide workers' compensation coverage for those workers, unless they meet the requirement for an exemption under ORS 656.126(2).

2. **Professional Liability:** ☒ **Required by OHA** ☐ **Not required by OHA.**

Professional Liability Insurance covering any damages caused by an error, omission or any negligent acts related to the services to be provided under the Provider Contract, with limits not less than the following, as determined by OHA, or such lesser amount as OHA approves in writing:

☒ Per occurrence for all claimants for claims arising out of a single accident or occurrence:

Provider Contract containing the following Services:	Required Insurance Amount:
A&D 03, A&D 60, A&D 62, A&D 63, A&D 64, A&D 65, A&D 66, A&D 80, A&D 81, A&D 82, A&D 83, A&D 84, MHS 01, MHS 04, MHS 05, , MHS 08, MHS 09, MHS 10, MHS 12, MHS 13, MHS 15, MHA 16, MHS 16A, MHS 20, MHS 24, MHS 25, MHS 26, MHS 26A, MHS30, MHS 34, MHS 34A, MHS 35, MHS 35A, MHS 35B, MHS 36, MHS 37, MHS 38, MHS 39, MHS	$1,000,000
A&D 61, A&D 67, A&D 71, MHS 27, MHS 28, MHS 28A, MHS 31	$2,000,000

3. **Commercial General Liability:** ☒ **Required by OHA** ☐ **Not required by OHA.**

Commercial General Liability Insurance covering bodily injury, death, and property damage in a form and with coverages that are satisfactory to OHA. This insurance shall include personal injury liability, products and completed operations. Coverage shall be written on an occurrence form basis, with not less than the following amounts as determined by OHA, or such lesser amount as OHA approves in writing:

Bodily Injury, Death and Property Damage:

☒ Per occurrence for all claimants for claims arising out of a single accident or occurrence:

Provider Contract containing the following services:	Required Insurance Amount:
A&D 03, A&D 60, A&D 61, A&D 62, A&D 63, A&D 64, A&D 65, A&D 66, A&D 67, A&D 71, A&D 80, A&D 81, A&D 82, A&D 83, A&D 84MHS 01, MHS 04, MHS 05, MHS 06, MHS 08, MHS 09, MHS 10, MHS 12, MHS 13, MHS 15, MHS 16, MHS 16A, MHS 20, MHS 24, MHS 25, MHS 26, MHS 26A, MHS 27, MHS 28, MHS 28A, MHS 30, MHS 31, MHS 34, MHS 34A, MHS 35, MHS 35A, MHS 35B, MHS 36, MHS 37, MHS 38, MHS 39	$1,000,000

4. **Automobile Liability:** ☒ **Required by OHA** ☐ **Not required by OHA.**

Automobile Liability Insurance covering all owned, non-owned and hired vehicles. This coverage may be written in combination with the Commercial General Liability Insurance (with separate limits for "Commercial General Liability" and "Automobile Liability"). Automobile Liability Insurance must be in not less than the following amounts as determined by OHA, or such lesser amount as OHA approves in writing:

Bodily Injury, Death and Property Damage:

☒ Per occurrence for all claimants for claims arising out of a single accident or occurrence:

Provider Contract not-to-exceed under this Agreement:	Required Insurance Amount:
A&D 61, A&D 62, A&D 63, A&D 66, A&D 71, A&D 81, A&D 82, A&D 83, MHS 04, MHS 09, MHS 12, MHS 13, MHS 15, MHS 16, MHS 16A, MHS 20, MHS 24, MHS 25, MHS 26, MHS 26A, MHS 30, MHS 34, MHS 34A, MHS 36, MHS 37, MHS 39,	$1,000,000
MHS 27, MHS 28, MHS 28A	$2,000,000

5. **Additional Insured.** The Commercial General Liability insurance and Automobile Liability insurance must include the State of Oregon, its officers, employees and agents as Additional Insureds but only with respect to the Provider's activities to be performed under the Provider Contract. Coverage must be primary and non-contributory with any other insurance and self-insurance.

6. **Notice of Cancellation or Change.** The Provider or its insurer must provide written notice to County at least 30 calendar days before cancellation of, material change to, potential exhaustion of aggregate limits of, or non-renewal of the required insurance coverage(s).

7. **"Tail" Coverage.** If any of the required insurance policies is on a "claims made" basis, such as professional liability insurance, the Provider shall maintain either "tail" coverage or continuous "claims made" liability coverage, provided the effective date of the continuous "claims made" coverage is on or before the effective date of the Provider Contract, for a minimum of 24 months following the later of : (i) the Provider's completion and County 's acceptance of all Services required under the Provider Contract; or (ii) the expiration of all warranty periods provided under the Provider Contract. Notwithstanding the foregoing 24-month requirement, if the Provider elects to maintain "tail" coverage and if the maximum time period "tail" coverage reasonably available in the marketplace is less than the 24-month period described above, then the Provider may request and OHA may grant approval of the maximum "tail" coverage period reasonably available in the marketplace. If OHA approval is granted, the Provider shall maintain "tail" coverage for the maximum time period that "tail" coverage is reasonably available in the marketplace.

8. **Certificate(s) of Insurance.** County shall obtain from the Provider a certificate(s) of insurance for all required insurance before the Provider performs under the Provider Contract. The certificate(s) or an attached endorsement must specify: i) all entities and individuals who are endorsed on the policy as Additional Insured; and ii) for insurance on a "claims made" basis, the extended reporting period applicable to "tail" or continuous "claims made" coverage.

2021 INTERGOVERNMENTAL AGREEMENT
FOR THE FINANCING OF COMMUNITY MENTAL HEALTH, ADDICTION TREATMENT, RECOVERY, & PREVENTION, AND PROBLEM GAMBLING SERVICES

EXHIBIT K
START-UP PROCEDURES

Addiction Treatment, Recovery, & Prevention, and Problem Gambling (Service Element A&D 60)
Community Mental Health (Service Element MHS 37)

INTRODUCTION

Start-Up funds are awarded for expenses necessary to begin, expand, or improve services. These expenses are distinct from routine operating expenses incurred in the course of providing ongoing services.

Start-Up funds are typically disbursed prior to initiation of services. Funds are used to cover costs such as employee salaries and training, furnishings and supplies, renovation of facilities under $10,000, and purchase of vehicles and other capital items that will be needed to provide the services planned and delivered at the specified sites.

Requirements for Start-Up Payment

Payment of Start-Up funds is subject to the following requirements and any Special Conditions which are specified in Exhibit C.

1. **Basis and Method of Payment**

   a. Funds are paid for actual allowable expenses up to the limit specified for Start-Up. Allowable expenses for each service element are limited to those listed under Allowable Start-Up Expenditures in this Exhibit. OHA must approve payment for all Start-Up funds.

   b. After execution of this Agreement or any amendment(s) awarding Program Start-Up funds, County may request an advance of funds it anticipates using in the subsequent 120 calendar days.

   c. A request for payment of Start-Up funds may only be made using forms and procedures prescribed by OHA. Special instructions are applicable as follows:

      (1) When OHA Start-Up funds in the amount of $1,000 and above are to be used for purchase of a vehicle, as security for the County's performance of its obligations under this Agreement, the County grants to OHA a security interest in, all of the County's right, title, and interest in and to the goods, i.e. the vehicle. The County agrees that from time to time, at its expense, the County will promptly execute and deliver all further instruments and documents, and take all further action, that may be necessary or desirable, or that OHA may reasonably request, in order to perfect and protect the security interest granted under this Agreement or to enable OHA to exercise and enforce its rights and remedies under this Agreement with respect to the vehicle. County must forward a copy of the title registration application showing Health Systems Division as the Security Interest Holder to OHA within 5 calendar days of the acquisition from the seller. File Security Interest Holder information as follows:

      Oregon Health Authority
      Health Systems Division
      500 Summer Street NE, E86
      Salem, OR 97301

(2) When County requests payment of Start-Up funds, the request must be made on forms prescribed by OHA.

2. **Special Written Approval Authorizations**

When using Start-Up funds the following circumstances require special written authorization from OHA prior to acquisition. These circumstances should be communicated to OHA within 14 calendar days of the anticipated acquisition date.

a. **WHEN LEASING:**

(1) Acquisition of real property, vehicles or capital items pursuant to a Lease;

(2) Acquisition of real property, vehicles, or capital items where another party, in addition to OHA, will also become a secured party (lienholder) at the time of acquisition; and

(3) Renovations or alterations of real property where County is not the owner of the property and OHA has no security interest in the property.

b. **OTHER:**

A change in the intended use of Start-Up funds or a change in the amount or date of anticipated acquisition indicated on County's request for payment of Start-Up funds, for those acquisitions requiring OHA's interest to be secured.

3. **Release of Payments**

Following review and approval of County's request for payment of Start-Up funds and any ancillary documentation, OHA will issue an advance of funds to County as applicable. These funds will generally be issued as a separate check on a weekly basis; however, requests processed in time for the monthly allotment process will be included in the allotment. The request for funds should be communicated to OHA within 14 calendar days of the anticipated acquisition date. Approval of special requests will be made on a limited basis only.

County will keep a copy of all Requests for Payment of Start-Up funds and report actual expenditures to OHA on the same form using procedures prescribed by OHA.

4. **Start-Up Expenditure Documentation Maintained by County**

County shall maintain an Expenditure Report for Start-Up payments. County also is responsible for requiring its Providers to comply with expenditure reporting requirements and furnishing evidence of filing OHA's security interest on applicable items. OHA may inspect these reports. The reports must include the following by service element:

a. The amount advanced;

b. The amount expended on each allowable category, and the amount expended on each item listed as required in Special Written Approval Authorizations above and pre-approved by OHA; and

c. Copies of all Provider Contracts awarding Start-Up funds. Such Provider Contracts must require Providers to have executed dedicated use agreements and the other security documentation described in this Exhibit.

County must maintain supporting documentation for all expenditures (i.e., receipts).

5. Expenditure Reports to OHA

County must submit Start-Up expenditure reports separately for each OHA Start-Up request. Expenditure reports are due within 45 calendar days following the termination or expiration of the Agreement. County shall report actual expenditure of Start-Up funds, using forms and procedures prescribed by OHA, and forward expenditure reports to OHA.

6. Recovery of Start-Up Funds

In the event County fails to submit an expenditure report when due for itself or its Provider(s), fails to submit security interests, vehicle titles, or other instrument as required by OHA to secure the State's interest, or reports unauthorized expenditures, or reports under expenditures without accompanying repayment, OHA may act, at its option, to recover Start-Up funds as follows:

a. Bill County for subject funds;

b. Following 30 calendar days nonresponse to the billing, initiate an allotment reduction schedule against any current payments or advances being made to County; or

c. Take other action needed to obtain payment.

7. Dedicated Use Requirement

Vehicles costing $1,000 or more must be used to provide the service for which OHA approved the Start-Up funds. Dedicated use must continue for the useful life of the vehicle or five years whichever is less.

8. Removal of Liens

The following steps describe the process for removal of liens:

To release a vehicle title on which OHA is listed security interest holder, County or any of its' Providers, must make a request in writing to OHA. The request must specify why the vehicle is being disposed of and the intended use of any funds realized from the transaction.

If approved, the original title is signed off by OHA and forwarded to County.

ALLOWABLE START-UP EXPENDITURES

Community Mental Health, Addiction Treatment, Recovery, & Prevention, and Problem Gambling

1. **Policies**: Start-Up funds:
   - **a.** Must be expended consistent with County's request for payment of Start-Up funds, and/or any required itemized budget, as approved by OHA.
   - **b.** Must be expended only for items and services listed below.
   - **c.** Must not be used for personnel costs, facility costs (as defined below) or equipment lease costs (including vehicle leases) in any month in which the provider receives OHA-funded service payments, or room and board payments for clients.
   - **d.** Are subject to dedicated use requirements and other procedures for securing the State's interest, as described within this Exhibit.

   Exceptions to the policies stated above and/or the itemized list below must be approved in writing by HSD.

2. **Allowable Costs**
   - **a.** **Personnel Costs**: Costs for personnel hired to work at program/facility incurred prior to the date clients are enrolled.
     - **(1)** Salaries and wages up to 2 months for Program Administrator and up to 2 weeks for program staff, or as otherwise approved by OHA;
     - **(2)** OPE costs; and
     - **(3)** Professional contract services (e.g., Psychiatrist, Specialized Treatment Providers, etc.).
   - **b.** **Facility Costs**: Up to 2 months prior to opening, or as otherwise approved by OHA.
     - **(1)** Lease/mortgage payments and deposits;
     - **(2)** Property taxes and maintenance fees not included in lease or mortgage payments;
     - **(3)** Utility costs, including hook-up fees;
     - **(4)** Equipment rental costs; and
     - **(5)** Initial insurance premiums (general liability and professional liability insurance).
   - **c.** **Program Staff Training**: Up to 2 weeks for program staff, or as otherwise approved by OHA:
     - **(1)** Training materials;
     - **(2)** Training fees;
     - **(3)** Trainer fees; and
     - **(4)** Travel costs (excluding out of state).
   - **d.** **Services and Supplies**:
     - **(1)** Program and office supplies; and
     - **(2)** Initial supplies of food, maintenance, and housekeeping items.

e. **Capital Outlay**:

(1) Furnishings and equipment appropriate for the type of service being provided, e.g., household furnishings and appliances for residential programs;

(2) Technical or adaptive equipment needed by clients but not available through the Adult and Family Services (client medical card), Vocational Rehabilitation, or other appropriate service agency;

(3) Office furnishings and equipment proportionate to size of residential program/staff being implemented;

(4) Vehicle purchases or down payment; lease payments and deposits; as well as costs for purchase and/or installation of necessary adaptive equipment such as lifts or ramps; and

(5) Renovation of real property costing less than $10,000.

2021 INTERGOVERNMENTAL AGREEMENT
FOR THE FINANCING OF COMMUNITY MENTAL HEALTH, ADDICTION TREATMENT, RECOVERY, & PREVENTION, AND PROBLEM GAMBLING SERVICES

EXHIBIT L
CATALOG OF FEDERAL DOMESTIC ASSISTANCE (CFDA) NUMBER LISTING

Crook County				
Service Description #	**Service Description Name**	**Vendor or Sub-recipient**	**All Funding Sources**	**CFDA #**
MHS 01	System Management and Coordination		N/A	
A&D 03	System Management and Coordination - Addictions Services		N/A	
A&D 60	Start-Up - Addictions Services		N/A	
A&D 61	Adult Addiction Treatment, Recovery & Prevention Residential Treatment Services		N/A	
A&D 62	Supported Capacity for Dependent Children Whose Parents are in Adult Addition Residential Treatment		N/A	
A&D 63	Peer Delivered Services		N/A	
A&D 64	Housing Assistance		N/A	
A&D 65	Intoxicated Driver Program Fund (IDPF)		N/A	
A&D 66	Community Behavioral and Addiction Treatment, Recovery & Prevention Services	Subrecipient	SAPT	93.959
A&D 67	Addiction Treatment, Recovery & Prevention Residential & Day Treatment Capacity		N/A	
A&D 71	Youth Addiction, Recovery & Prevention Residential Treatment Services		N/A	
A&D 80	Problem Gambling Prevention Services		N/A	
A&D 81	Problem Gambling Treatment Services		N/A	
A&D 82	Problem Gambling Residential Services		N/A	
A&D 83	Problem Gambling Respite Treatment Services		N/A	
A&D 84	Problem Gambling Client Finding Outreach Services		N/A	
MHS 04	Aid and Assist Client Services		N/A	

MHS 05	Assertive Community Treatment Services		N/A	
MHS 08	Crisis and Acute Transition Services (CATS)		N/A	
MHS 09	Jail Diversion		N/A	
MHS 10	Mental Health Promotion and Prevention Services		N/A	
MHS 12	Rental Assistance Program Services		N/A	
MHS 13	School-Based Mental Health Services		N/A	
MHS 15	Young Adult Hub Programs (YAHP)		N/A	
MHS 16	Peer Delivered Services (PDS)		N/A	
MHS 16A	Veterans Peer Delivered Services		N/A	
MHS 20	Non-Residential Mental Health Services For Adults	Subrecipient	MHBG	93.958
MHS 22	Non-Residential Mental Health Services For Child and Youth		N/A	
MHS 24	Acute and Intermediate Psychiatric Inpatient Services		N/A	
MHS 25	Community MH Crisis Services for Adults and Children		N/A	
MHS 26	Non-Residential Mental Health Services for Youth & Young Adults In Transition		N/A	
MHS 26A	Early Assessment and Support Alliance (EASA)		N/A	
MHS 27	Residential Mental Health Treatment Services for Youth and Young Adults In Transition		N/A	
MHS 28	Residential Treatment Services		N/A	
MHS 28A	Secure Residential Treatment Facility		N/A	
MHS 30	Monitoring, Security and Supervision Services for Individuals under the Jurisdiction of the Adult and Juvenile Panels of the Psychiatric Security Review Board		N/A	
MHS 31	Enhanced Care and Enhanced Care Outreach Services		N/A	
MHS 34	Adult Foster Care Services		N/A	

MHS 35	Older or Disabled Adult Mental Health Services		N/A	
MHS 35A	Gero-Specialist		N/A	
MHS 35B	APD Residential		N/A	
MHS 36	Pre-Admission Screening and Resident Review Services (PASRR)		N/A	
MHS 37	Start-Up - Community Mental Health		N/A	
MHS 38	Supported Employment Services		N/A	
MHS 39	Projects For Assistance In Transition From Homelessness Services (PATH)		N/A	

In compliance with the Americans with Disabilities Act, this document is available in alternate formats such as Braille, large print, audio recordings, Web-based communications and other electronic formats. To request an alternate format, please send an e-mail to dhs-oha.publicationrequest@state.or.us or call 503-378-3486 (voice) or 503-378-3523 (TTY) to arrange for the alternative format.

FIRST AMENDMENT TO OREGON HEALTH AUTHORITY 2020-2021 INTERGOVERNMENTAL AGREEMENT FOR THE FINANCING OF MENTAL HEALTH, ADDICTION TREATMENT, RECOVERY, & PREVENTION, AND PROBLEM GAMBLING SERVICES AGREEMENT #166039

This First Amendment to Oregon Health Authority 2021 Intergovernmental Agreement for the Financing of Community Mental Health, Addiction Treatment, Recovery, & Prevention, and Problem Gambling Services effective as of January 1, 2021 (as amended, the "Agreement"), is entered into, as of the date of the last signature hereto, by and between the State of Oregon acting by and through its Oregon Health Authority ("OHA") and **Crook County** ("County").

RECITALS

WHEREAS, OHA and County wish to modify the Financial Assistance Award set forth in Exhibit C of the Agreement.

NOW, THEREFORE, in consideration of the premises, covenants and agreements contained herein and other good and valuable consideration the receipt and sufficiency of which is hereby acknowledged, the parties hereto agree as follows:

AGREEMENT

1. The financial and service information in the Financial Assistance Award are hereby amended as described in Attachment 1 attached hereto and incorporated herein by this reference. Attachment 1 must be read in conjunction with the portion of Exhibit C of the Agreement that describes the effect of an amendment of the financial and service information.
2. Capitalized words and phrases used but not defined herein shall have the meanings ascribed thereto in the Agreement.
3. County represents and warrants to OHA that the representations and warranties of County set forth in section 4 of Exhibit F of the Agreement are true and correct on the date hereof with the same effect as if made on the date hereof.
4. Except as amended hereby, all terms and conditions of the Agreement remain in full force and effect.
5. This Amendment may be executed in any number of counterparts, all of which when taken together shall constitute one agreement binding on all parties, notwithstanding that all parties are not signatories to the same counterpart. Each copy of this Amendment so executed shall constitute an original.

IN WITNESS WHEREOF, the parties hereto have executed this amendment as of the dates set forth below their respective signatures.

6. Signatures.

Crook County
By:

Authorized Signature	Printed Name	Title	Date

State of Oregon acting by and through its Oregon Health Authority
By:

Authorized Signature	Printed Name	Title	Date

Approved by: Director, OHA Health Systems Division
By:

Authorized Signature	Printed Name	Title	Date

Approved for Legal Sufficiency:

Approved by Steven Marlowe, Senior Assistant Attorney General, Department of Justice, Tax and Finance Section, on April 30, 2019; e-mail in contract file.

OHA Program:

Approved by Theresa Naegeli on March 15, 2021; e-mail in contract file.

ATTACHMENT 1

EXHIBIT C
Financial Pages

MODIFICATION INPUT REVIEW REPORT

MOD#: M0263

CONTRACT#: 166039 CONTRACTOR: CROOK COUNTY

INPUT CHECKED BY: _____ DATE CHECKED: _____

SE#	FUND	PROJ CODE	CPMS PROVIDER	EFFECTIVE DATES	SLOT CHANGE/TYPE	RATE	OPERATING DOLLARS	STARTUP DOLLARS	PART ABC	PART IV	PART CD	BASE	CLIENT CODE	SP#
FISCAL YEAR: 2020-2021														
	BASE		NON-RESIDENTIAL MENT											
20	401		MHNRMH	7/1/2021 - 6/30/2021	0 /N/A	$0.00	$135,982.91	$0.00	A		1	Y		
				TOTAL FOR SE# 20			$135,982.91	$0.00						
				TOTAL FOR 2020-2021			$135,982.91	$0.00						
FISCAL YEAR: 2021-2022														
	BASE		NON-RESIDENTIAL MENT											
20	401		MHNRMH	7/1/2021 - 12/31/2021	0 /N/A	$0.00	$135,982.91	$0.00	A		1	Y		
				TOTAL FOR SE# 20			$135,982.91	$0.00						
				TOTAL FOR 2021-2022			$135,982.91	$0.00						
				TOTAL FOR M0263 166039			$251,965.82	$0.00						

OREGON HEALTH AUTHORITY
Financial Assistance Award Amendment (FAAA)

CONTRACTOR: CROOK COUNTY
DATE: 03/10/2021

Contract#: 166039
REF#: 002

REASON FOR FAAA (for information only):

Non-Residential Community Mental Health Services For Adults (MHS 20), payments are added.

DOCUMENT RETURN STATEMENT

Please complete the following statement and return with the completed signature page and the Contractor Data and Certification page and/or Contractor Tax Identification Information (CTII) form, if applicable.

If you have any questions or find errors in the above referenced Document, please contact the contract specialist.

Document number: _____ , hereinafter referred to as "Document."

I, _____ _____

Name Title

received a copy of the above referenced Document, between the State of Oregon, acting by and through the Department of Human Services, the Oregon Health Authority, and

_____ by email.

Contractor's name

On _____ ,

Date

I signed the electronically transmitted Document without change. I am returning the completed signature page, Contractor Data and Certification page and/or Contractor Tax Identification Information (CTII) form, if applicable, with this Document Return Statement.

_____ _____

Authorizing signature Date

Please attach this completed form with your signed document(s) and return to the contract specialist via email.

Crook County Legal Counsel

Mailing: 300 NE Third St., Rm 10, Prineville, OR 97754 • Phone: 541-416-3919
Physical: 267 NE 2nd St., Ste 200, Prineville, OR 97754 • Fax: 541-447-6705

MEMO

TO: Crook County Court

FROM: Eric Blaine, County Counsel

DATE: April 28, 2021

RE: Recommendation for award of electric charging station installation contract
Our File No.: Fairgrounds # 91(B)

The County received a grant from Pacific Power for, among other purposes, the installation of an electric vehicle charging station at the County Fairgrounds. In furtherance of this project, the County promulgated an informal solicitation under ORS 279B.070. Two firms attended the mandatory pre-bid meeting. The deadline to submit proposals was 2pm yesterday, and the County received one bid. We have been informed that the other firm had trouble obtaining a quote for concrete work, and so may try to submit a late bid.

Unfortunately, the on-time bid was not in conformance with the solicitation's requirements. While the price was stated as being $14,860.00,[1] EC Electric submitted a cover letter purporting to modify its submission. In particular, the cover letter states in a variety of locations that the price quoted is not firm, and that EC Electric may raise the price depending on circumstances beyond the County's control. Those include: costs for equipment and supplies; rates for labor under EC Electric's union contract; Oregon's Corporate Activity Tax; any overtime EC Electric may have to pay[2]; and other matters.

For this reason, it is my advice that EC Electric's proposal is non-responsive.

Based on where we are now, the County has two choices:

- Not accept the proposal, and re-publish the project solicitation.
- Award the contract to EC Electric, despite their proposal being non-responsive, as presenting the best value to the County.

After reviewing Oregon's public contracting law regarding late proposals, it is my recommendation that the County award the contract to EC Electric, with a goal of obtaining more certainty regarding the price.

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[1] Under CCC 3.12.040, this is within the range of prices that one County commissioner is authorized to approve.
[2] Please note that the final project completion date is stated for October 4, 2021.

If a late proposal is received between the time this memo is sent for inclusion in the Agenda Packets and May 5's meeting, I will inform the County Court.

Based on the forgoing, I would recommend a motion that:

> "The County Court award a contract with EC Electric for the installation of an electric vehicle charging station, to direct staff to establish final terms, and to authorize Judge Crawford to sign on behalf of the County."

Please let me know if you have any questions.

Please place this memo and the attached document(s) on the Wednesday, May 5, 2021 County Court agenda, as a Discussion item.

EC electric

ecpowerslife.com

April 27, 2021

ATTN: Crook County Administration Office
300 NE Third St
Prineville, OR 97754
Casey.Daly@co.crook.or.us

Re: Crook County Fairgrounds EV Charging Stations

EC Electric proposes the budgeting price of **$14,860.00** for consideration as a best value solution for your design build project located at Crook County Fairgrounds, Prineville, OR.

General Clarifications

- Proposal pricing is based on the following documents:
  - Bidder's Proposal Packet – Charging Station Supply Purchase and Installation 04/01/21
  - Addendum 1 04/19/21
- Project Schedule:
  - Work schedule is anticipated to be a standard 5x8's work schedule, with work performed Monday through Friday, 7:00am through 4:30pm.
- This proposal is subject to the successful negotiation of a mutually agreeable contract.
- Warranty for items not furnished by EC Electric are limited to installation of that equipment; the supplier shall carry the warranty for the equipment being supplied.
- Due to the limited availability of skilled craftsman, EC's cost of work might be impacted by increases in rates and burdens that could not have been reasonably anticipated by EC as of the date of this proposal and is subject to change and/or escalation if not accepted within the time set forth below.
- No daily labor incentives have been included in this proposal.
- Labor rates are based on our current union agreement through 2021 and include burden. Once an agreement has been reached for 2022, and 2023 the labor rates will be adjusted accordingly.
- As your trusted partner of choice, EC must inform our clients of included costs associated with trade tariffs, Oregon business taxes, and Portland Clean Energy Surcharge taxes [if applicable] levied against us. EC is in constant negotiation with vendors and partners to limit the impact to our client partners. These costs are included in this proposal for acceptance up to *05.27.2021* and subject to change and/or escalation if accepted thereafter. Further levied costs and taxes after this date will require renegotiation between EC and our client partners.
- Existing electrical installations assumed to be installed per code requirements.
- This proposal excludes pricing associated with any tax not in effect as of the date of this proposal. This proposal Includes pricing associated with the Oregon Corporate Activity Tax under HB 3427, which became effective January 1, 2020, or any bills to correct, clarify or amend the same (collectively CAT). The parties acknowledge that the Department of Revenue (DOR) has identified numerous issues with the Oregon Corporate Activity Tax (CAT) that need to be addressed. Accordingly, the parties agree that the ultimate Subcontract Price shall be adjusted at Final Completion to include net tax payments incurred or to be incurred as a result of CAT and that a provision addressing the same will be included in the Subcontract.
- Proposal pricing is valid for 30 days.

EC electric

ecpowerslife.com

Scope of Work Clarifications

- Procurement and Installation of (2) Pedestal EV Charging stations.
  - ZEF Energy Pedestal Mount charging stations. 25' charging chord. 4g cellular communication. 5 year cellular data package $160/plug/per year to be purchased upon installation.
  - (2) dedicated 40amp feeds (est 80' underground PVC) from Existing Main Service.
- Trenching from Main Service to proposed charging pedestal pad locations
  - Excavation, Earthmoving, trenching & backfill activities
- Concrete pad 4'x4'x8" pedestal pad.
- Procurement and installation of (2) Protective Bollards.
- Electrical Permits Included.
- Utility Coordination.

Exclusions

- Premium or overtime pay.
- Hazardous material handling and disposal.
- Structural steel, framing, or metal fabrication.
- Roof penetrations and/or repair.
- Any and/or all cutting, patching, and painting has been excluded.
- Trenching activities assumes 24"W x 24" Depth. Rock-breaking activities have been excluded. Hydro hammering activities.
- Damages to existing utilities & landscaping
- Material escalation in excess of 10% from the time of proposal expiration date.

Thank you for the opportunity to provide this proposal. Please feel free to contact me with any questions, comments, or to be of further assistance. EC looks forward to being your trusted partner of choice on this project.

Respectfully,

Digitally signed by Grant Oberholzer
DN: C=US, E=grant.oberholzer@ecpowerslife.com, O=EC Electric, OU=Redmond, CN=Grant Oberholzer
Date: 2021.04.27 11:09:21 -07'00'

Grant Oberholzer
Project Manager
Grant.oberholzer@ecpowerslife.com
541.405.0787

BIDDER'S PROPOSAL PACKET

CROOK COUNTY FAIRGROUNDS
1280 SE MAIN STREET
PRINEVILLE, OREGON 97754

PROJECT INFORMATION

Project Name: Charging Station Supply Purchase and Installation

Project Manager: Whit Jamieson, Forth Mobility

Mandatory Pre-Bid Meeting: Friday, April 9, 2021 @ 1:00 p.m.

Submittal Deadline: Tuesday, April 20, 2021 @ 2:00 p.m.

Expected Award Date: Monday, April 26, 2021.

Crook County Fairgrounds is seeking services for the equipment purchase and the installation of two (2) charging stations (see Scope of Services, Exhibit C, attached hereto).

PROCEDURES; PREPARATION OF PROPOSALS

Pursuant to ORS 279B.070, proposals for the 2021 Crook County Fairgrounds Charging Station Installation Project will be received until **Tuesday, April 20, 2021 at 2:00 p.m.** at the Crook County Administration Office in Prineville, Oregon. Postmarks will not be used to determine date of receipt. Each proposal must be submitted to one of the addresses below:

Mail/Hand Delivery:
Crook County Fairgrounds
c/o Crook County Administration Office
300 NE Third Street
Prineville, OR 97754

Electronic Submission:
Casey.Daly@co.crook.or.us

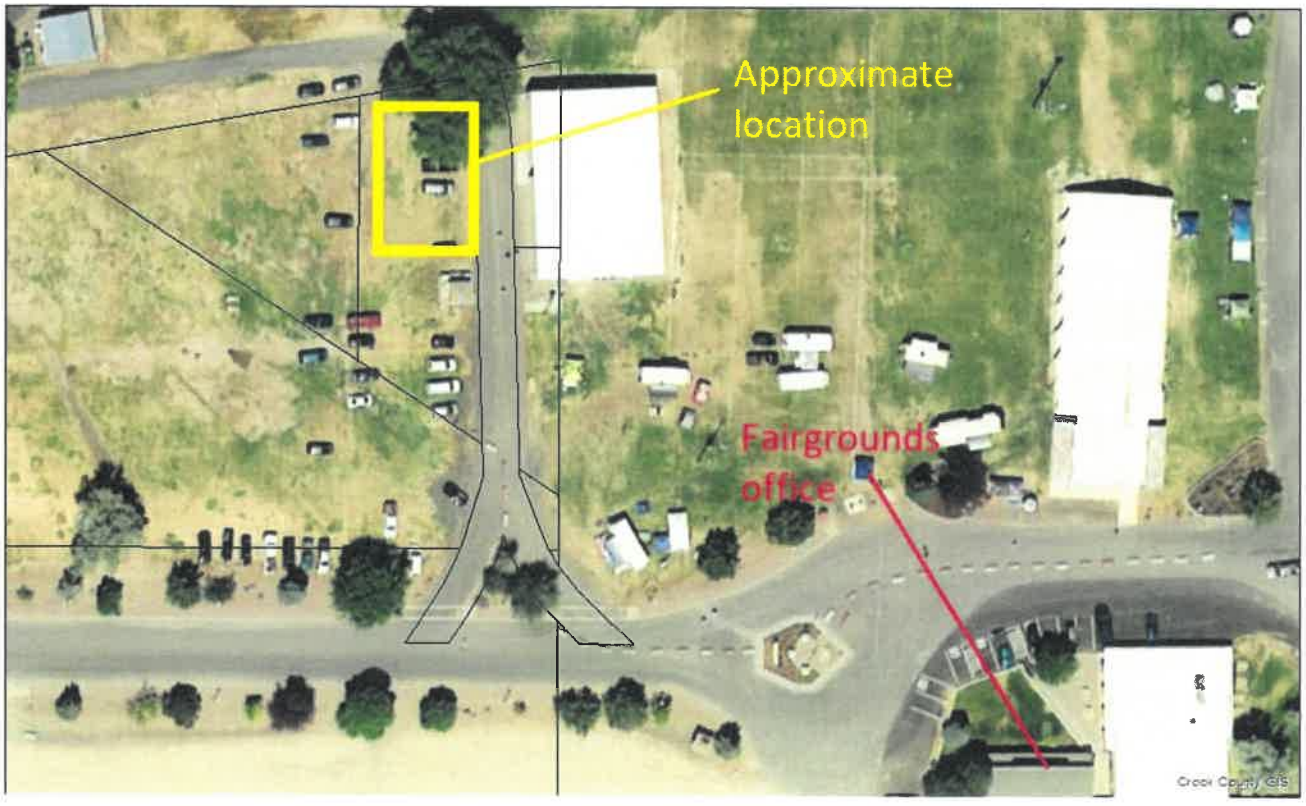
The start date for this project shall be no sooner than **Monday, April 26, 2021,** with a completion date of no later than **Monday, October 4, 2021.**

PROJECT SCOPE

Crook County, Oregon is seeking qualified bidders to acquire and install either

- Two (2) electric vehicle charging stations, or
- One (1) dual port/plug electric vehicle charging station;

at its Fairgrounds. The specifications for the charging station equipment are contained in Exhibit C, attached hereto. The proposed location for the charging stations is illustrated below, subject to the terms of a final contract to be approved by the County and the successful bidder.



The project is made possible with support from Pacific Power and the Oregon Clean Fuels Program.

PREBID MEETING

Areas of work and excavation will be identified at the Pre-Bid Meeting.

Limited Effect: Statements and other information from County employees and/or representatives at a pre-bid meeting do not affect any change in the project documents, or the contracts that may arise from them. Changes in specifications, requirements, or due dates may be effected only by a written addendum issued by the County. The County may notify bidders or proposers of addenda by any method deemed appropriate to provide actual notice, including but not limited to: mail, telephone, email, or facsimile. Bidders and proposers may rely only upon the project documents, with any changes made by addendum, to establish all of the procurement requirements and all contract provisions other than those established by the bid or proposal.

RIGHTS RESERVED BY THE COUNTY

No proposals shall be received or considered by the County unless the bidder is registered with the Construction Contractor's Board as required by ORS 671.530.

County is not obligated to accept any proposal, negotiate with any bidder, award a contract, or proceed with the development of any project described in response to this solicitation.

County nor any of its agents are committed by this proposal request to enter into any agreement, pay any costs incurred in the preparation of any response, or procure or contract for any product, services or supplies. The County reserves the right to accept or reject any or all responses to the proposal request, to request proposals from any, all or none of the applicants or any other individual, or to delay or cancel this proposal request, in part or in its entirety, if it is in the best interests of the County to do so. Responses to this proposal request are entirely voluntary and made with this knowledge.

It is the policy of Crook County to provide equal employment opportunity for all persons in compliance with federal and state laws without regard to race, color, religion, sex, age, national origin, physical or mental disability.

NOT SUBJECT TO PREVAILING WAGE RATE

This project is <u>not</u> subject to prevailing wages, per Oregon Revised Statute (ORS) 279C.810.

COMPLIANCE WITH APPLICABLE LAWS

By submitting this proposal, bidder certifies conformance with all federal, state and local laws, regulations, executive orders and ordinances applicable to the work under the contract, including without limitation:

(4) Titles VI and VII of the Civil Rights Act of 1964 as amended;
(II) Title V and Section 503 and 504 of the Rehabilitation Act of 1973 as amended;
(III) The Americans and Disabilities Act of 1990 as amended and as supplemented by ORS 659A.103;

(IV) The Health Insurance Portability & Accountability Act of 1996;
(V) The Age Discrimination in Employment Act of 1967, as amended, and the Age Discrimination Act of 1975, as amended;
(VI) The Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended;
(VII) All federal and state laws and regulations concerning Affirmative Action toward equal employment opportunities;
(VIII) All regulations and administrative rules established pursuant to the foregoing laws; and
(IX) All other applicable requirements of federal and state civil rights and Sewer Upgrade statutes, rules, and regulations.

These laws, regulations, and executive orders are incorporated by reference herein to the extent that they are applicable to the contract and required by law to be so incorporated.

INSURANCE

The successful bidder will be required to carry public liability insurance and worker's compensation insurance at all times. The successful bidder will, no later than the date of execution of the contract and prior to the commencement of the work, deliver to the County certificates of insurance as evidence of compliance with **the insurance provisions set forth in the *sample* Construction Contract, attached hereto as *Exhibit A*.**

PROPOSAL BOND

Each proposal must be submitted on the required form and be accompanied by a cashier's check, certified check, irrevocable letter of credit per ORS 75.1020, or surety bond payable to "Crook County" in an amount of not less than ten percent (10%) of the amount of the proposal. The bidder shall require the attorney-in-fact who executes the required bonds on behalf of the surety to affix thereto a certified and current copy of the power of attorney.

PERFORMANCE AND PAYMENT BONDS

The bidder shall furnish bonds covering the faithful performance of the contract and payment of all obligations arising thereunder. The bonds shall be from a surety company authorized to transact surety business in the state of Oregon. A **performance bond** in the amount equal to the full contract price conditioned on the faithful performance of the contract in accordance with the plans, specifications and conditions of the contract and a **payment bond** in an amount equal to the full contract price, shall be provided by the bidder, at bidder's cost. The bidder shall deliver the required bonds to the County prior to or contemporaneous with execution of the construction contract. The bonds shall be dated on or after the date of the contract. The bidder shall require the attorney-in-fact who executes the required bonds on behalf of the surety to affix thereto a certified and current copy of the power of attorney.

EVALUATION AND ACCEPTANCE OF PROPOSAL (AWARD)

It is the intent of the County to award a contract to the proposal will best serve the interests of the County, taking into account price as well as considerations including, but not limited to, experience, expertise, product functionality, suitability for a particular purpose and contractor responsibility under ORS 279B.110.

The selected proposal must be submitted in accordance with the requirements of the bidding documents, is judged to be reasonable, and does not exceed the funds available. The County shall have the right to waive informalities and irregularities in a proposal received and to accept the proposal which, in the County's judgment, is in the County's best interests. Any protest of award must be filed with the County within two (2) calendar days of the proposal due date. Before commencing work, the successful bidder shall be required to execute a Construction Contract, using substantially the form attached hereto as Exhibit A, and incorporated herein by reference.

Non-Discrimination Certification – By signing this proposal, bidder certifies:

- He/she has not discriminated against minority, women, or small business enterprises in obtaining any subcontracts.

Residency Certification: Refer to ORS 279A.120(1).

Complete the following:

1. **Check one: Bidder is a** X **resident bidder**___ **nonresident bidder.**

2. **If a resident bidder, enter your Oregon business address**:

   2747 SW 6th St, Suite 101, Redmond, OR 97756

3. **If a nonresident bidder, enter state of residency**:

Tax Laws Compliance Certification – By signing this proposal, bidder certifies:

- To the best of its knowledge, the bidder is not in violation of any Oregon tax laws.

Contractor's Board Registration Certification – By signing this proposal bidder certifies:

Bidder is in compliance with requirements for construction contractors or landscape contractors and is registered and bonded with the Construction Contractor's Board or licensed by the Landscape Contractor's Board as follows:

No. CCB#: 49737 Expiration Date 01/05/2022

Contractor's Certification of Drug Testing Program ORS 279C.505(2) – By signing this proposal bidder certifies:

- The bidder will have a drug testing policy in place at time of contract award.
- The bidder shall maintain the drug testing policy for the duration of the contract.
- The bidder shall require each subcontractor providing labor to this contract to comply with the drug testing requirements.

Statement Regarding Certifications

- The bidder understands and acknowledges that the above representations are material and important and will be relied on by the Crook County Court, in awarding the contract for which this proposal is submitted. The bidder understands that any misstatement in these certifications is and shall be treated as fraudulent concealment from Crook County, of the true facts relating to the submission of proposals for the contract.

All work and materials must comply with the adopted City of Prineville Standard Specifications and State of Oregon Electrical Code. The Standard Specifications are available on the City of Prineville website www.cityofprineville.com.

PROPOSAL SUMMARY

Equipment Acquisition	$7,118
Installation (including mobilization)	$7,742
Total Price	$ 14,860

CHARGING STATION INFORMATION

Manufacturer: ZEF Energy

Model Number: ZEFNET-40-CWS-4G

Charging Rate: 7.7 kW

Connection Type: 208/240V

NEMA Rating: NEMA 4

Meets the requirements of UL 2594? Yes [x] No [ ]

Bidder Name: EC Electric

Signature of Authorized Agent: 

Federal ID No: 93-0902566

Address: 2747 SW 6th St, Suite 101, Redmond, OR 97756

Phone #: 800.598.4266

PROPOSAL BOND

CROOK COUNTY FAIRGROUNDS ELECTRIC CHARGING STATION PROJECT

KNOW ALL MEN BY THESE PRESENTS, that _____

_____

a surety company duly organized under the laws of the State of _____ having its principal place of business at _____

in the State of _____, and authorized to do business in the State of Oregon, is held and firmly bound unto Crook County, in the full sum of ten percent (10%) of the total amount of the proposal for the work hereinafter described, for the payment of which, well and truly to be made, we bind ourselves, our heirs, executors, administrators and assigns, and successors and assigns, firmly by these presents.

The condition of this bond is such that, whereas _____ (Bidder) is herewith submitting its proposal for the following work, to wit: acquisition and installation of two (2) electric charging stations as specified in the solicitation document dated _____.

All work is to be completed by **Monday, October 4, 2021.**

NOW THEREFORE, if said proposal submitted by said bidder is accepted by Crook County, Oregon, and the contract for said work is awarded to said bidder, and if the said bidder enters into and executes the said contract and furnishes bond and insurance as required by the County within the time fixed by the County, then this obligation shall be void; otherwise to remain in full force and effect. These obligations shall not be impaired or affected by any extension of time within which the County may accept the proposal or the required submittals, and Surety waives notice of any such extensions.

Signed and sealed this _____ day of_____, 20___.

SURETY	**PRINCIPAL**
_____ (Surety Company)	_____ (Principal (Bidder))
_____ (Signature)	_____ (Signature)

CONSTRUCTION CONTRACT

In consideration of the covenants herein below set forth, * hereafter referred to as **CONTRACTOR**, and CROOK COUNTY, A POLITICAL SUBDIVISION OF THE STATE OF OREGON, ACTING BY AND THROUGH ITS COUNTY COURT, hereafter referred to as **CROOK COUNTY**, mutually contract as follows:

1. **CONTRACTOR** agrees and covenants to perform and complete the work herein described and provided for and furnish all machinery, necessary tools, apparatus, equipment, supplies, materials, and labor, and do all things in accordance with the applicable specifications and any such alterations or modifications of this contract as may be made by **CROOK COUNTY**, and according to such directions as may from time to time be made or given by the Project Manager, under authority and within the meaning and purpose of this contract. The contract documents and proposal specifications provided in the bid proposal document, any addenda, and the Bid Schedule of contract prices in the **CONTRACTOR**'s proposal are hereby incorporated by reference as if the same were fully set out in writing and inserted herein. The total cost to **CROOK COUNTY** for this project is * **DOLLARS AND * /100 ($*)**, complete with all material, labor, and equipment as may be necessary for the faithful and professional performance of this contract as may be required by **CROOK COUNTY** in accordance with plans and specifications all of which are incorporated herein by reference. All of said plans and specifications, the required bonds and insurance documents, and this contract and its attachments (**Attachments A through C**), constitute the contract documents.

2. Any conflict or difference between the contract documents shall be called to the attention of **CROOK COUNTY** by **CONTRACTOR** before proceeding with affected work. In case of any conflict or any discrepancy between the contract documents, the specific provisions of this contract shall have priority over all others.

3. **CONTRACTOR** agrees to complete full performance in accordance with all plans and specifications by *. Time is of the essence in this contract. Because of the difficulty of computing actual damages, liquidated damages of One Hundred Dollars ($100) per calendar day shall be assessed if work is not completed and accepted on *. The parties agree that this paragraph is a reasonable forecast of just compensation caused by the breach and is not a penalty.

4. Any progress payment shall be due according to contract specifications; final payment shall be due when the contract has been fully performed according to its terms. **CROOK COUNTY** shall make payment when **CONTRACTOR** submits evidence satisfactory to **CROOK COUNTY** of having appropriately paid all payrolls, material bills, and other indebtedness connected with the work, and of having fully complied with all laws and terms of the contract. Payment shall be made promptly in accordance with ORS 279C.500 – 279C.545, and both parties shall have all the rights and duties (including the right to withhold retainage) specified in ORS 279C.550 – 279C.570 regarding payment.

5. **CONTRACTOR** agrees that **CROOK COUNTY** shall not be responsible or liable to pay any sum of money over the contract total of *[TBD]**/100 DOLLARS ($*[TBD])**, except that **CROOK COUNTY** agrees to pay **CONTRACTOR** based on actual quantities of work performed and other basis of payment specified, taking into account any amounts that may be deductible under this contract, provided that the work performed is in accordance with the contract, is satisfactorily performed at the direction of the Project Manager, and is covered, if necessary for **CROOK COUNTY** budget purposes, by a contract amendment. Notwithstanding any term contained herein to the contrary, **CROOK COUNTY** shall not be liable or responsible for any payment for

additional work or cost unless **CROOK COUNTY** specifically assumes in writing such responsibility and liability on and by itself.

6. **CONTRACTOR** shall comply with all provisions included in the Bidder's Proposal and are hereby incorporated by this reference.

7. The performance of this contract is at **CONTRACTOR'S** sole risk. The service or services to be rendered under this contract are those of an independent contractor who is not an officer, employee, or agent of the County as those terms are used in ORS 30.265. **CONTRACTOR** is solely liable for any workers' compensation coverage, social security, unemployment insurance or retirement payments, and federal or state taxes due as a result of payments under this contract. Any subcontractor hired by **CONTRACTOR** shall be similarly responsible.

8. **CONTRACTOR** agrees to indemnify, defend, and hold **CROOK COUNTY**, its Commissioners, agents, officers, and employees harmless and defend all damages, losses, and expenses, included but not limited to attorney's fees, and to defend all claims, proceedings, lawsuits, and judgments arising out of or resulting from the fault of the **CONTRACTOR**, the **CONTRACTOR'S** agents, representatives, or subcontractors in the performance of or failure to perform this contract. However, **CONTRACTOR** shall not be required to indemnify any indemnitee to the extent the damage, loss, or expense is caused by the indemnitee's negligence.

9. By execution of this contract, **CONTRACTOR** certifies under penalty of perjury that to the best of **CONTRACTOR'S** knowledge, **CONTRACTOR** is not in violation of any tax laws described in ORS 305.380(4), and **CONTRACTOR** has not discriminated against minority, women, or small business enterprises in obtaining any required subcontract.

10. By execution of this contract, **CONTRACTOR** agrees to have an employee drug-testing program in place at the time of executing the contract, and that such a program will be maintained throughout the contract period, including any extensions. The failure of **CONTRACTOR** to have or maintain such a drug testing program is grounds for immediate termination of the contract. The **CONTRACTOR** shall require each subcontractor providing labor for the project to also comply with this drug testing program requirement.

11. **CROOK COUNTY** shall not be liable, either directly or indirectly, for any dispute arising out of the substance or procedure of **CONTRACTOR'S** drug testing program. Nothing in this drug testing provision shall be construed as requiring **CONTRACTOR** to violate any legal rights, including constitutional rights, of any employee, including but not limited to selection of which employees to test and the manner of such testing. **CROOK COUNTY** shall not be liable for **CONTRACTOR'S** negligence in establishing or implementing, or failure to establish or implement a drug testing policy, or for any damage or injury caused by **CONTRACTOR'S** employees acting under the influence of drugs while performing work covered by this contract. These are **CONTRACTOR'S** sole responsibilities and nothing in this provision is intended to create any third party beneficiary rights against **CROOK COUNTY**.

12. **CONTRACTOR** may only substitute a first-tier subcontractor that was not disclosed under ORS 279C.585 in accordance with statutory criteria, including demonstration of inadvertent error, the subcontractor's failure or refusal to execute or perform under a written contract, to meet bond requirements, to perform substantially satisfactory work or affirmatively causing substantial delay or disruption to work progress, subcontractor's bankruptcy or insolvency, or failure to be registered with Construction Contractors Board, if

required, or otherwise be eligible to work on a public improvement project pursuant to applicable statutory requirements.

13. **CONTRACTOR** is solely responsible for ensuring that any subcontractor selection and substitution has been in accordance with all legal requirements. **CROOK COUNTY** shall not be liable, either directly or indirectly, in any dispute arising out of the **CONTRACTOR'S** actions with regard to subcontractor selection and substitution.

14. **CROOK COUNTY** reserves the right to reject any proposal or to refuse delivery of materials or services at or from any manufacturer, plant, or contractor with which **CROOK COUNTY** has reasonable grounds to believe is or may be operating in violation of any local, state, or federal laws, or which is the subject of pending litigation.

15. Modifications or amendments to this contract shall be effective only if in writing and executed by both parties. This document is the entire, final, and complete agreement of the parties pertaining to this Construction Contract, and supersedes and replaces all prior or existing written and oral agreements between the parties or their representatives.

16. **CONTRACTOR** shall make payment promptly, as due, to all persons supplying to such **CONTRACTOR** labor or material for the prosecution of the work provided for in the contract, and shall be responsible for payment to such persons supplying labor or material to any subcontractor.

17. **CONTRACTOR** shall pay promptly all contributions or amounts due to the State Industrial Accident Fund and the State Unemployment Compensation Fund from **CONTRACTOR** or any subcontractor in connection with the performance of the contract.

18. **CONTRACTOR** shall not permit any lien or claim to be filed or prosecuted against **CROOK COUNTY** due to any labor or material furnished by **CONTRACTOR**. **CONTRACTOR** shall assume responsibility for satisfaction of any lien so filed or prosecuted and shall defend against, indemnify, and hold **CROOK COUNTY** harmless from any such lien or claim.

19. **CONTRACTOR** and any subcontractor shall pay to the Department of Revenue all sums withheld from employees pursuant to ORS 316.167.

20. If **CONTRACTOR** fails, neglects, or refuses to make prompt payment of any claim for labor or services furnished to the **CONTRACTOR** or a subcontractor by any person in connection with the public contract as such claim becomes due, **CROOK COUNTY** may pay such claim to the person furnishing the labor or services and charge the amount of the payment against funds due or to become due to the **CONTRACTOR** by reason of the contract. The payment of a claim in the manner authorized hereby shall not relieve the **CONTRACTOR** or its surety from the obligation with respect to any unpaid claim. If **CROOK COUNTY** is unable to determine the validity of any claim for labor or services furnished, **CROOK COUNTY** may withhold from any current payment due **CONTRACTOR** an amount equal to said claim until its validity is determined, and until the claim, if valid, is paid by the **CONTRACTOR** or **CROOK COUNTY**. There shall be no financial acceptance of the work under the contract until all such claims have been resolved.

21. **CONTRACTOR** shall make payment promptly, as due, to any person, co-partnership, association, or corporation furnishing medical, surgical, hospital, or other needed care and attention, incident to sickness or injury, to the employees of **CONTRACTOR**, of all sums which the **CONTRACTOR** agreed to pay or collected or deducted from the wages of employees pursuant to any law, contract, or agreement for the purpose of providing payment for such service.

22. For all public contracts, with certain exceptions listed below, **CONTRACTOR** shall not employ an employee for more than ten (10) hours in any one day, or forty (40) hours in any one week except in case of necessity, emergency, or where public policy absolutely requires otherwise, and in such cases **CONTRACTOR** shall pay the employee at least time and a half for:

(a.) All overtime in excess of eight (8) hours a day or forty (40) hours in any one week when the work week is five (5) consecutive days, Monday through Friday, and

(b.) All overtime in excess of ten (10) hours a day or forty (40) hours in any one week when the work week is four (4) consecutive days, Monday through Friday, and

(c.) All work performed on the days specified in ORS 279C.540.

(d.) The **CONTRACTOR** shall comply with the prohibition set forth in ORS 652.220, that compliance is a material element of the contract and that a failure to comply is a breach that entitles the contracting agency to terminate the contract for cause.

(e.) The **CONTRACTOR** may not prohibit any of the **CONTRACTOR'S** employees from discussing the employee's rate of wage, salary, benefits, or other compensation with another employee or another person and may not retaliate against an employee who discusses the employee's rate of wage, salary, benefits, or other compensation with another employee of another person.

23. **CONTRACTOR** must give notice to employees who work on a public contract in writing, either at the time of hire or before commencement of work on the contract, or by posting a notice in a location frequented by employees, of the number of hours per day and days per week that the employees may be required to work.

24. The **CONTRACTOR**, its subcontractors, if any, and all employers working under the contract are subject employers under the Oregon Workers' Compensation Law and shall comply with ORS 656.017, which requires them to provide workers' compensation coverage for all their subject workers.

25. **CONTRACTOR** shall comply with all applicable federal, state, and local laws and regulations, including but not limited to those dealing with the prevention of environmental pollution and the preservation of natural resources that affect the performance of the contract. A list of entities that have enacted such laws or regulations is found in the Oregon Attorney General's Model Public Contract Rules Manual.

26. This contract may be cancelled at the election of **CROOK COUNTY** for any substantial breach, willful failure, or refusal on the part of **CONTRACTOR** to faithfully perform the contract according to its terms. **CROOK COUNTY** may terminate the contract by written order or upon request of the **CONTRACTOR** if the work cannot be completed for reasons beyond the control of either the **CONTRACTOR** or **CROOK COUNTY**, or for any reason considered to be in the public interest other than a labor dispute, or by reason of any third party judicial proceeding relating to the work other than one filed in regards, and when circumstances or conditions are such that it is impracticable within a reasonable time to proceed with a substantial portion of the work. In either case, if the work is suspended but the contract not terminated, the **CONTRACTOR** is entitled to a reasonable time extension, costs, and overhead per ORS 279C.655. Unless otherwise stated in the contract, if the contract is terminated due to the public interest, the **CONTRACTOR** shall be paid per ORS 279C.660.

27. If **CROOK COUNTY** does not appropriate funds for the next succeeding fiscal year to continue payments otherwise required by the contract, the contract will terminate at the end of the last fiscal year for which payments have been appropriated. **CROOK COUNTY** will notify **CONTRACTOR** of such non-appropriation not later than thirty (30) days before the beginning of the year within which funds are not appropriated. Upon termination pursuant to this clause, **CROOK COUNTY** shall have no further obligation to the **CONTRACTOR** for payments beyond the termination date. This provision does not permit **CROOK COUNTY** to terminate the contract in order to provide similar services or goods from a different contractor.

28. **CONTRACTOR** agrees to prefer goods or services that have been manufactured or produced in this State if price, fitness, availability, or quality are otherwise equal.

29. **CONTRACTOR** agrees to not assign this contract or any payments due hereunder without the proposed assignee being first approved and accepted in writing by **CROOK COUNTY**.

30. **CONTRACTOR** agrees to make all provisions of the contract with **CROOK COUNTY** applicable to any subcontractor performing work under the contract.

31. **CROOK COUNTY** will not be responsible for any losses or unanticipated costs suffered by **CONTRACTOR** as a result of **CONTRACTOR'S** failure to obtain full information in advance in regard to all conditions pertaining to the work.

32. **CONTRACTOR** certifies that he/she has all necessary licenses, permits, or certificates of registration (including Construction Contractors Board registration or Landscape Contractors Board license, if applicable), necessary to perform the contract and further certifies that all subcontractors shall likewise have all necessary licenses, permits, or certificates before performing any work. The failure of **CONTRACTOR** to have or maintain such licenses, permits, or certificates is grounds for rejection of a proposal or immediate termination of the contract.

33. **CONTRACTOR** certifies that **CONTRACTOR** is "responsible" as that term is defined in ORS 279C.375 and that **CONTRACTOR:**

(a.) has available the appropriate financial, material, equipment, facility, and personnel resources and expertise, or has the ability to obtain the resources and expertise necessary to meet all contractual responsibilities; and
(b.) holds current licenses in this State in order to undertake or perform the work specified in the contract; and
(c.) is covered by liability insurance and other insurance in amounts the contracting agency requires in the solicitation documents; and
(d.) qualifies as a carrier-insured employer or a self-insured employer, or has elected coverage under State Worker's Compensation Law; and
(e.) has made the first tier subcontractor disclosure required by the contracting agency; and
(f.) has completed previous contracts of a similar nature with the satisfactory record of performance; and
(g.) has a satisfactory record of integrity; and
(h.) is legally qualified to contract with the contracting agency; and
(i.) supplied all necessary information in connection with the inquiry concerning responsibility; and
(j.) possesses an unexpired certificate issued by the Oregon Department of Administrative Services if the **CONTRACTOR** employs fifty (50) or more full-time workers and submitted a proposal for a procurement with an estimated contract price that exceeds $500,000.

34. **CONTRACTOR** represents and warrants that **CONTRACTOR** has complied with the tax laws of this State or a political subdivision of this State, including but not limited to ORS 305.620 and ORS Chapters 316, 317, and 318. **CONTRACTOR** covenants to continue to comply with the tax laws of this State or a political subdivision of this State during the term of the public contract, and provides that **CONTRACTOR'S** failure to comply with the tax laws of this State or a political subdivision of this State before the **CONTRACTOR** executed the public contract or during the term of the public contract is a default for which **CROOK COUNTY** may terminate the public contract and seek damages and other relief available under the terms of the public contract or under applicable law.

35. It is a material condition of this contract that **CONTRACTOR** remain certified as a disadvantaged, minority, women, or emerging small business enterprise under ORS 200.055 or businesses that service-disabled veteran owns for the entire term of the public contract, whenever **CROOK COUNTY** awards the public contract, in whole or in part, on the basis of the **CONTRACTOR'S** certification.

(a.) **CONTRACTOR** shall provide in the **CONTRACTOR'S** subcontracts that a subcontractor remain certified as a disadvantaged, minority, women, emerging small business enterprise under ORS 200.055, or businesses that service-disabled veteran owns for the entire term of the subcontract, if the **CONTRACTOR** awards the subcontract, in whole or in part, on the basis of the subcontractor's certification.

36. Unless otherwise provided, data which originates from this contract shall be "works for hire" as defined by the U.S. Copyright Act of 1976 and shall be owned by **CROOK COUNTY**. Data shall include, but not be limited to, reports, documents, pamphlets, advertisements, books, magazines, surveys, studies, computer programs, films, tapes, and/or sound reproductions. Ownership includes the right to copyright, patent, register and the ability to transfer these rights. Data which is delivered under the contract, but which does not originate therefrom shall be transferred to **CROOK COUNTY** with a nonexclusive, royalty-free, irrevocable license to publish, translate, reproduce, deliver, perform, dispose of, and to authorize others to do so; provided that such license shall be limited to the extent which the **CONTRACTOR** has a right to grant such license. **CONTRACTOR** shall exert all reasonable effort to advise **CROOK COUNTY**, at the time of delivery of data furnished under this contract, of all known or potential invasions of privacy contained therein and of any portion of such document which was not produced in the performance of this contract. **CROOK COUNTY** shall receive prompt written notice of each notice or claim of copyright infringement received by **CONTRACTOR** with respect to any data delivered under this contract. **CROOK COUNTY** shall have the right to modify or remove any restrictive markings placed upon the data by **CONTRACTOR**.

37. [RESERVED]

38. If **CONTRACTOR** or a first-tier subcontractor fails, neglects, or refuses to make payment to a person furnishing labor or materials in connection with the public contract for a public improvement within thirty (30) days after receipt of payment from the public contracting agency or a **CONTRACTOR**, the **CONTRACTOR** or first-tier subcontractor shall owe the person the amount due plus interest charges commencing at the end of the ten (10) day period that payment is due under ORS 279C.580(4), and ending upon final payment, unless payment is subject to a good faith dispute as defined in ORS 279C.580. The rate of interest charged to the **CONTRACTOR** or first-tier subcontractor on the amount due shall equal three (3) times the discount rate on ninety (90) day commercial paper in effect at the Federal Reserve Bank in the Federal Reserve District that includes Oregon on the date that is thirty (30) days after the date when payment was received from the public contracting agency, or from the **CONTRACTOR**, but the rate of interest shall not exceed thirty percent (30%). The amount of interest may not be waived.

39. If **CONTRACTOR** or subcontractor fails, neglects, or refuses to make payment to a person furnishing labor or materials in connection with the public contract, the person may file a complaint with the Construction Contractors Board, unless payment is subject to a good faith dispute as defined in ORS 279C.580.

40. In the event of an action, suit, or proceeding, including appeal therefrom, is brought for failure to observe any the terms of this agreement, each party shall bear its own attorney fees, expenses, costs, and disbursements for said action, lawsuit, proceeding, or appeal.

41. **CONTRACTOR** is engaged hereby as an independent contractor, and will be so deemed for all purposes. **CONTRACTOR** will be solely responsible for the payment of any federal or state taxes required as a result of this agreement. This contract is not intended to entitle **CONTRACTOR** to any benefits generally granted to **CROOK COUNTY** employees. Without limitation, but by way of illustration, **CONTRACTOR** is an independent contractor for purposes of the Oregon Workers' Compensation Law and is solely liable for any workers' compensation coverage under this contract.

42. This Construction Contract may be executed in one or more counterparts, including electronically transmitted counterparts, which when taken together shall constitute one in the same instrument. Facsimiles and electronic transmittals of the signed document shall be binding as though they were an original of such signed document.

IN WITNESS WHEREOF, the parties have executed this contract on the below said date.

CONTRACTOR

Business Name: _____

By: *Sample – Do Not* _____

Signature

Print Name

Its: _____

Date _____

Contractor's CCB #_

Telephone Number

Address

City State Zip

CROOK COUNTY

By: _____

Print: _____

Date: _____

Performance Bond

CROOK COUNTY FAIRGROUNDS ELECTRIC CHARGING STATION PROJECT

KNOW ALL MEN BY THESE PRESENTS: That we _____, as principal, and _____, a corporation organized and existing under and by virtue of the laws of the State of _____and duly authorized to transact surety business in the State of Oregon, as surety, are jointly and severally held and bound unto Crook County, in the sum of _____($_____) for the payment of which we jointly and severally bind ourselves, our heirs, executors, administrators and assigns or successors and assigns, firmly by these presents.

THE CONDITION OF THIS BOND IS SUCH

That, whereas the principal has made and entered into a certain contract, a copy of which is attached hereto, with Crook County, Oregon, which contract, together with the applicable plans, Standard Specifications, Special Provisions, and schedule of contract prices, is by this reference made a part, whereby the principal agrees to perform in accordance with the certain terms, conditions, requirements, plans and specifications which are set out in the contract and all authorized modifications of the contract which increase the amount of the work and the amount of the contract. Notice to surety of any of the immediately foregoing are waived.

NOW, THEREFORE, if the principal shall faithfully and truly observe and comply with the terms, conditions and provisions of the contract, in all respects, and shall well and truly and fully do and perform all matters and things by it undertaken to be performed under the contract, upon the terms set forth and within the time prescribed therein, or as extended as provided in the contract, and agrees to indemnify, defend and hold Crook County, its Commissioners, agents, officers and employees harmless and defend all damages, losses and expenses including but not limited to attorney's fees and to defend all claims, proceedings, lawsuits and judgments arising out of or resulting from the fault of the principal, the principal's agents, representatives or subcontractors, in the performance of or failure to perform this contract. However, principal shall not be required to indemnify any indemnitee to the extent the damage, loss or expense is caused by the indemnitee's sole negligence and shall in all respects perform said contract according to law, then this obligation is to be void, otherwise to remain in full force and effect. Nonpayment of the bond premium will not invalidate this bond nor shall Crook County be obligated for the payment thereof.

This Bond is given and received under the authority of ORS Chapter 279C.380, the provisions of which relating to performance bonds are incorporated into this Bond by this reference.

Witness our hands this _____day of _____, 20___.

PRINCIPAL: _____

Principal's Name (Print or Type)

By: _____

Authorized Official's Signature (Print or Type)

_____

Official Capacity (Print or Type)

PRINCIPAL: _____

Principal's Name (Print or Type)

By: _____

Authorized Official's Signature (Print or Type)

_____

Official Capacity (Print or Type)

SURETY: _____

_____

ATTORNEY IN FACT [POA must be attached to this bond]

_____

Agent

Attach additional signature page for Surety if using multiple bonds

Surety's Seal Must Be Affixed

Payment Bond

CROOK COUNTY FAIRGROUNDS ELECTRIC CHARGING STATION PROJECT

KNOW ALL MEN BY THESE PRESENTS: That we _____, as principal, and _____, a corporation organized and existing under and by virtue of the laws of the State of _____ and duly authorized to transact surety business in the State of Oregon, as surety, are jointly and severally held and bound unto Crook County, in the sum of _____ ($_____) for the payment of which we jointly and severally bind ourselves, our heirs, executors, administrators and assigns or successors and assigns, firmly by these presents.

THE CONDITION OF THIS BOND IS SUCH

That, whereas the principal has made and entered into a certain contract, a copy of which is attached hereto, with Crook County, Oregon, which contract, together with the applicable plans, Standard Specifications, Special Provisions, and schedule of contract prices, is by this reference made a part, whereby the principal agrees to perform in accordance with the certain terms, conditions, requirements, plans and specifications which are set out in the contract and all authorized modifications of the contract which increase the amount of the work and the amount of the contract. Notice to surety of any of the immediately foregoing is waived.

NOW, THEREFORE, if the principal shall make payment promptly, as due to all subcontractors and to all persons supplying to the contractor or its subcontractors, equipment, supplies, labor or materials for the prosecution of the work, or any part thereof, provided for in said contract, and, if applicable, shall pay not less than the State of Oregon Bureau of Labor and Industries prevailing wage rates in effect as of the date of the proposal, per hour, day and week for and to each and every worker who may be employed in and about the performance of the contract and shall pay all contribution amounts due for workers' compensation and all amounts due the State Unemployment Compensation Trust Fund from such contractor or subcontractors incurred in the performance of said contract, and pay all sums of money withheld from the contractor's employees and payable to the State Department of Revenue, and shall pay all other just debts, dues and demands incurred in the performance of the said contract and shall pay Crook County such damages as may accrue to Crook County under the contract, then this obligation is void, otherwise to remain in full force and effect, provided that surety will remain liable to satisfy the claim of any worker affected by the failure of the principal or any subcontractor under the contract to pay the minimum rate of wage in accordance with the contract in the amount of the unpaid minimum wages and an additional amount equal thereto as liquidated damages.

Nonpayment of the bond premium will not invalidate this Bond nor shall Crook County be obligated for the payment thereof.

This Bond is given and received under the authority of ORS Chapter 279C.380, the provisions of which relating to performance bonds are incorporated into this Bond by this reference.

Witness our hands this _____day of _____, 20___.

PRINCIPAL: _____

Principal's Name (Print or Type)

By: _____

Authorized Official's Signature (Print or Type)

_____

Official Capacity (Print or Type)

PRINCIPAL: _____

Principal's Name (Print or Type)

By: _____

Authorized Official's Signature (Print or Type)

_____

Official Capacity (Print or Type)

SURETY: _____

_____

ATTORNEY IN FACT [POA must be attached to this bond]

_____

Agent

Attach additional signature page for Surety if using multiple bonds

Surety's Seal Must Be Affixed

Exhibit A

Insurance Coverage (Marked Items Required)

CONTRACTOR shall not commence any work until **CONTRACTOR** obtains, at **CONTRACTOR'S** own expense, all required insurance as specified below. Approval of **CROOK COUNTY** is required as to limits, form, and amount. **CONTRACTOR** is required to obtain or maintain the following for the full period of the contract:

__X__ **COMMERCIAL GENERAL LIABILITY** insurance covering personal injury, bodily injury, and property damage with limits as specified below. The insurance shall include:

COVERAGES	LIMITS
_____Explosion & Collapse	_____$1 million per occurrence
_____Underground Hazard	__X__Limits of the Oregon Tort Claims Act
_____Products/Completed Operations	(ORS 30.260-30.300) presently at $1,538,300.00
__X__Contractual Liability	__X__Other – Tort limits adjusted per ORS 30.372(4) beginning 2015
_____Broad Form Property Damage	_____Owners & Contractors Protective

FORM: All policies must be of the occurrence form with combined single limit for bodily injury and property damage. Any deviation from this must be reviewed by the Crook County Counsel. All claims-made forms must have the prior approval of the Crook County Counsel. Submit a complete copy of claims-made policies and endorsements with the certificate of insurance.

_____ **AUTOMOBILE LIABILITY** insurance comprehensive form with limits as specified below. The coverage shall include owned, hired, and non-owned automobiles.

LIMITS

_____$1 million per occurrence

_____Other – Tort limits adjusted per ORS 30.372(4) beginning in 2015

_____Not less than the limits of the Oregon Tort Claims Act

(ORS 30.260-30.300) presently at $1,538,300.00 aggregate

_____ **PROFESSIONAL LIABILITY** insurance with limits not less than $_____.

__X__ **ADDITIONAL INSURED CLAUSE:** The liability insurance coverages required for the performance of this contract shall be endorsed to name Crook County, its commissioners, officers, agents, and employees as additional insured with respect to the activities performed under this contract.

__X__ **WORKERS' COMPENSATION AND EMPLOYER'S LIABILITY** as statutorily required for persons performing work under this contract. Any subcontractor hired by **CONTRACTOR** shall also carry Worker's Compensation and Employers' Liability coverage.

_____ **EMPLOYERS LIABILITY** insurance with limits of $500,000.

_____ **BUILDER'S RISK** insurance special form. Limits to be the value of the contract or $_____.

_____ **FIDELITY BOND** covering the activities of any person, named or unnamed, responsible for collection and expenditures of funds. Limit $_____ per employee.

In the event of cancellation or change of the information above, **CONTRACTOR** certifies that it will immediately notify the Department of said cancellation or change and will obtain alternate coverage.

Contractor Business Name: EC Electric

By: _____ Digitally signed by Jeff Klemp DN: C=US, E=jeff.klemp@ecpowerslife.com, O=EC Electric, OU=Albany Industrial, CN=Jeff Klemp Reason: I am approving this document Date: 2021.04.27 11:02:40-07'00'
Signature

Its: Project Executive

Date 4/27/21

Jeff Klemp
Print Name

Exhibit B

Workers' Compensation Insurance Certification

All subject employers working under this contract are either employers that will comply with ORS 656.017 or employers that are exempt under ORS 656.126. The Contractor for the purposes of this contract hereby certifies that it is currently providing workers' compensation coverage for all its employees and will maintain coverage throughout the course of the project through one of the following methods:

Employers Complying with ORS 656.017

1. ☒ "Carrier-insured employer" (State Accident Insurance Fund Corp. or other authorized insurer).

   Insurance Company Name: Ward Insurance Agency Inc.

   ID/Policy No.: BKS56400298

2. ☐ "Self-insured employer" (certified by the Workers' Compensation Division).

   ID number as assigned by the Workers' Compensation Division _____

3. ☐ I am an independent contractor and will perform all work under this contract without the assistance of others.

Employers Exempt under ORS 656.126

4. ☐ Workers' Compensation Coverage, State of Origin: Oregon

In the event of cancellation or change of the information above, Contractor certifies that it will immediately notify the Department of said cancellation or change and will obtain alternate coverage.

CONTRACTOR

EC Electric
Name of Company

By: _____ Digitally signed by Jeff Klemp DN: C=US, E=jeff.klemp@ecpowersllc.com, O=EC Electric, OU=Albany Industrial, CN=Jeff Klemp Reason: I am approving this document Date: 2021.04.27 11:03:10-07'00'

Dated: 4/27/21

Its: Jeff Klemp

_____
Print Name

REMINDER – ADDITIONAL INFORMATION NEEDED

Has your insurance carrier filed with Oregon Workers' Compensation Division a guaranty contract as proof of coverage for your employees working in Oregon?

Exhibit C

Scope of Services

Description of work: Provide all materials, labor, and equipment to perform all operations required to safely and correctly install charging stations at the Crook County Fairgrounds:

1. Equipment:

Contractor will obtain either two (2) 40-amp electric charging stations or one (1) dual-port EV station (each charging port with dedicated 40-amp circuits) with the following specifications:

- Minimum enclosure rating of NEMA Type 3R or 4.
- The equipment must be listed by a nationally recognized test laboratory as meeting the requirements of UL 2594 "Standard for Electric Vehicle Supply Equipment".
- The equipment must comply with the Americans with Disabilities Act (ADA).
- The equipment must use the standard SAE J1772 plug type.
- Provide a charging rate of 6 kW or higher.
- Include a pedestal or plans for mounting the equipment at an appropriate height/location.

The charging station(s) should have the following features:

- Cable Management System to help keep the cords off the ground (does not need to be an overhead retractable system).
- Metering and remote monitoring through the use of cellular connectivity.
- Open to member and non-member EV drivers (if applicable).
- Accept payment options such as a phone application-required (available on both iOS and Android phones), an RFID card-optional, and tap to pay with credit cards-optional.

2. Installation:

Contractor will excavate the Fairgrounds installation site designated by Crook County, and, in conformance with the applicable City of Prineville and Oregon state specialty codes:

- Work with Crook County, Forth Mobility (the County's project manager), and the Crook County Fairgrounds to finalize specifications and plans for the install site.
- Provide site plan including electrical diagram and pictures.
- Obtain the necessary permits.
- Provide utility connection specifications and work with Crook County, Crook County Fairgrounds, and Pacific Power to ensure utility specifications are met.
- Install the chargers as specified in and commission the equipment so as to allow for charging of electric vehicles.
- Install EV charging signage (provided from Pacific Power).

3. Completion Date: All aspects of this project must be completed by Monday, October 4, 2021.

Crook County Counsel's Office

Mailing: 300 NE Third St., Prineville, OR 97754 • Phone: 541-416-3919
Physical: 267 NE 2nd St., Ste 200, Prineville, OR 97754 • Fax: 541-447-6705

MEMO

TO: Crook County Court

FROM: John Eisler, Assistant County Counsel

DATE: April 28, 2021

RE: Substance Use Disorders Treatment and Recovery Services RFP

Our File No.: Comm Corr 45

On March 16, 2021 the County solicited proposals for an array of substance use disorders treatment and recovery services to serve the Crook County Specialty Court D participants. The solicitation was advertised in the Bend Bulletin, the County's website, and sent directly to possible proposers. The RFP was open for approximately three and a half weeks, closing on April 9. The County received proposals from two entities: Turning Points Recovery Services, Inc. (Turning Points) and Imagine Freedom, LLC (Imagine Freedom). Both proposals were responsive and both proposers are responsible.

An evaluation committee composed of Specialty Court staff, District Attorney staff, and local defense attorneys reviewed and scored the proposals. The proposals were scored in five areas: administrative capability (15 pts), project description (35 pts), performance measures and program evaluations (15 pts), qualifications of staff and staffing plan (25 pts), and fiscal responsibility/budget (10 pts). The final total scores were as follows[1]:

Firm	Scorer #1	Scorer #2	Scorer #3	Scorer #4	Total Avg. Score
Turning Points	100	n/s	82	90	**90.67**
Imagine Freedom	90	n/s	64	44	**66**

Both Lieutenant Brett Lind and Sheriff John Gautney recommend accepting the scores and awarding the contract to Turning Points as the proposer whose proposal best serves the interest of Crook County. Please let me know if you have any questions.

Please place this memo and the attached document(s) on the Wednesday, May 5, 2021 County Court Agenda as a DISCUSSION ITEM for approval and signatures.

Approved this 5th day of May, 2021.

CROOK COUNTY COURT

Seth Crawford
County Judge

Jerry Brummer
County Commissioner

Brian Barney
County Commissioner

[1] Scorer #2 struggled to apply the scoring system and instead supplied a general critique of each proposal.

IN THE COUNTY COURT OF THE STATE OF OREGON
FOR THE COUNTY OF CROOK

IN THE MATTER OF:
DECLARATION OF LOCAL DROUGHT AND REQUEST TO DECLARE A STATE OF DROUGHT EMERGENCY FOR CROOK COUNTY, OREGON

RESOLUTION AND ORDER 2021-24

WHEREAS, on this 5th day of May 2021, the Crook County Court finds that the Crook County agricultural and livestock industries, recreation, and related economies are suffering widespread and severe economic damage, potential injuries, and loss of property resulting from extreme weather conditions within the county; and

WHEREAS, annual water supplies available for irrigators and ranchers within Crook County are a function of winter snowpack for water storage in Ochoco and Prineville Reservoirs and natural flows in the Crooked River and its tributaries; and

WHEREAS, seasonal precipitation, from October 1, 2020 to present is less than 70% of the average, and April precipitation is less than 50% of the average, with National Drought Mitigation Center reports that Crook County is in D3 (Extreme Drought) in the west portion of the County and D2 (Severe Drought) in the east portion of the County as of April 22, 2021; and

WHEREAS, Prineville Reservoir storage is roughly one-third below the average and Ochoco Reservoir is roughly two-thirds below average storage; and

WHEREAS, Ochoco Reservoir's 11,700 acre-feet of storage is at or near the all-time low since constant record keeping began in 1980, with expected 2020-21 run-off at less than a third of the yearly average; and

WHEREAS, Prineville Airport has recorded just 2.62 inches of precipitation this crop water year (September to present), with a historical average in the area of around 10 inches; and

WHEREAS, the extended weather forecast for Crook County for the next three months projects a 33-40% chance of higher than normal temperatures and 40-50% chance of below average precipitation; and

WHEREAS, the above conditions result in loss of economic stability, pasture shortages, decrease in feed production, shortened growing season, reduction in recreational opportunities, and decreased water supplies for Crook County agricultural and livestock producers; and

WHEREAS, the Crook County Court determines that extraordinary measures must be taken to alleviate suffering of people and livestock and to protect or mitigate economic loss, and to be responsive to the threat of wildfires.

NOW, THEREFORE, BE IT PROCLAIMED by the Crook County Court that:

1. A severe, continuing drought is declared within Crook County.

2. Crook County drought Emergency Management Plan has been implemented.

3. Pursuant to ORS 536.720, we find that appropriate response is beyond the capability of Crook County. We are declaring a state of emergency for the purpose of assessment, evaluation and acquiring the ability to provide appropriate available resources.

4. **Request:** The Honorable Kate Brown, Governor of Oregon, declare a Drought Emergency for all of Crook County under the provisions of ORS 536.740 due to severe and continuing drought conditions beginning at this time and continuing for an unknown period of time; and direct the Oregon Department of Water Resources to make available in Crook County: Temporary Transfers of Water Rights, and Emergency Water Use Permits, and Use of Existing Right Option/Agreement; and other federal and state drought assistance and programs as needed.

5. This proclamation shall take effect immediately from and after its issuance.

BE IT FURTHER ORDERED that this Order be filed in the Crook County Clerk's Office and that it be effective when so filed.

Adopted this 5th day of May 2021.

CROOK COUNTY COURT

_____

SETH CRAWFORD, County Judge

_____

JERRY BRUMMER, County Commissioner

Vote:	Aye	Nay	Abstain	Excused
Seth Crawford	___	___	___	___
Jerry Brummer	___	___	___	___
Brian Barney	___	___	___	___

_____

BRIAN BARNEY, County Commissioner