CHOICE MODEL SERVICES AGREEMENT

Choice Model Services Agreement
Deschutes County Health Services

Effective: January 1, 2022 – December 31, 2022

This Choice Model Services Agreement is entered into effective as of the 1st day of January, 2022 (hereinafter referred to as the Effective Date) by and between**, PacificSource Community Solutions,** an Oregon non-profit corporation (**"Health Plan"**) and **Deschutes County Health Services** (**"Provider"**) and shall expire on the 31st day of December, 2022 unless extended or terminated earlier in accordance with its terms.

RECITALS

WHEREAS, Health Plan is 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 and other target populations as defined in this agreement;

WHEREAS, Health Plan desires to enter into this Agreement with Provider to provide Covered Services to Individuals as described in this Agreement.

WHEREAS, the parties intend that should any 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, any Agreements between Health Plan and state or government agencies, or other legal requirements, as applicable.

NOW, THEREFORE, in consideration of the mutual covenants and agreements, and subject to the conditions and limitations set forth in this Agreement, and for the mutual reliance of the parties in this Agreement, the parties hereby agree as follows:

AGREEMENTS

1. **Definitions.**

   1.1 "Acute Care Psychiatric Facility" or "Acute Care Psychiatric Hospital" shall mean a hospital that provides 24 hour-a-day psychiatric, multi-disciplinary, inpatient or residential stabilization, care and treatment, for adults ages 18 years of age or older with serious psychiatric disabilities.

   1.2 "Agreement" shall mean Choice Model Services Agreement, including any and all amendments, exhibits, attachments, schedules, and addenda, now or hereafter entered into, between Provider and Health Plan.

   1.3 "Assertive Community Treatment (ACT)" shall mean an evidence-based practice designed to provide comprehensive treatment and support services to Individuals with SPMI. ACT is intended to serve Individuals who have serious 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 two case managers, and are designed to meet the individual needs of each Individual 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:

a. Low client to staff ratios;

b. Providing services in the community rather than in the office;

c. Shared caseloads among team members;

d. 24-hour staff availability;

e. Direct provision of all services by the team (rather than referring Individuals to other agencies); and

f. Time-unlimited services.

1.4 "Behavioral Health Treatment" shall mean treatment for mental illness, substance use disorders, or problem gambling.

1.5 "County of Responsibility" (COR) shall mean the county in which an Individual most recently maintained a postal address, or if residence is otherwise indeterminate, the county where the Individual was last present before being transported to an acute psychiatric hospital such as where the Individual was placed on a police officer custody, director's custody or transport custody. Incarceration or placement on an involuntary hold, at OHS or a licensed 24-hour facility, is not to be used to make this determination. OHA will determine COR if there is a disagreement between counties.

1.6 "Discharge Plan" shall mean a written document prepared by the Provider beginning at admission and updated through the Discharge Planning process which identifies housing, treatment and other services needed to support the continuity of care necessary to maintain the Individual's stability in the community. This report shall combine information from the Individual, OHS, community providers, recovery plan, and other resources.

1.7 "Discharge Planning" shall mean a process that begins upon admission to OSH or licensed residential setting and is based on the presumption that with sufficient supports and services, all Individuals can live in an integrated community setting. Discharge planning is developed and implemented through a person-centered planning process in which the Individual has a primary role in creating, and is based on principles of self-determination.

1.8 "Exceptional Needs Care Coordination (ENCC)" shall mean a process-oriented activity to facilitate ongoing communication and collaboration with the Individual to arrange Services appropriate to their needs, preferences and choices, including but not limited to:

a. Facilitating communication between the Individual, family, natural supports and community resources, involved providers, and agencies;

b. Organizing, facilitating, and participating in interdisciplinary team meetings when the Individual is in the community;

c. Emphasizing discharge planning in IDTs at OSH by collaborating with IDT members, providing recommendations in collaboration with CCO Care Coordinators towards discharge preparation and sharing revisions of the Discharge Plan;

d. Providing for continuity of care by creating linkages to and managing transitions between levels of care and transitions for adults with SPMI; and

e. In collaboration with CCO Care Coordinators, facilitating all referrals from OSH with the goal of providing oversight and care coordination for Adults with SPMI.

1.9 "Face-to-Face" shall mean a personal interaction where both words can be heard and facial expressions can be seen in person or through telehealth services where there is a live streaming audio and video.

1.10 "Home and Community-Based Services (HCBS)" shall mean the 1915 (i) state Medicaid plan amendment that allows for the use of Medicaid funding for home-based habilitation, behavioral habilitation, and psychosocial rehabilitation services for qualified Medicaid recipients who have been diagnosed with a mental illness.

1.11 "Home CCO" shall mean enrollment in a Coordinated Care Organization (CCO) in a given service area, based upon an Individual's most recent permanent residency, determined at the time of original eligibility determination or most current point of CCO enrollment prior to hospitalization per enrollment requirements in OAR 410-141-306.

1.12 "Individual" or "Client" shall mean, with respect to a particular Service, any person who is enrolled in that Service, in whole or in part, with payments provided under this Agreement.

1.13 "In-Reach Services" shall mean services delivered from community-based service providers to an Individual while at the Oregon State Hospital (OSH) or acute care psychiatric hospital to:

a. Maintain the Individual's connection to ongoing services and supports;

b. Assist with stabilization and discharge planning; and

c. Provide transition support for Individuals determined Ready to Transfer from the OSH or determined appropriate for diversion from OSH while in an acute care psychiatric hospital.

1.14 "Integrated Setting" shall mean a setting that enables Individuals with disabilities to interact with non-disabled persons to the fullest extent possible. Integrated settings are those that provide Individuals with disabilities opportunities to live, work, and receive services in the greater community, like individuals without disabilities. Integrated settings are:

a. Located in mainstream society;

b. Offer access to community activities and opportunities at times, frequencies and with persons of an Individual's choosing;

c. Afford Individuals choice in their daily life activities; and

d. Provide Individuals with disabilities the opportunity to interact with non-disabled persons to the fullest extent possible.

1.15 "Long-Term Psychiatric Care (LTPC)" shall mean inpatient psychiatric services delivered in an Oregon State-operated Hospital after usual and customary care has been provided in an acute inpatient hospital psychiatric care setting and the Individual continues to require a hospital level of care.

1.16 "Oregon State Hospital (OSH)" shall mean any campus of the Oregon State Hospital system.

1.17 "Peer Delivered Services" shall mean community-based services and supports provided by peers, and Peer Support Specialists, to Individuals or family members with similar lived experience. These services are intended to support Individuals and families, to engage Individuals in ongoing treatment, and to live successfully in the community.

1.18 "Ready To Transition (RTT)" shall mean the date that, consistent with the scope of the order of commitment, OSH has determined that an Individual is no longer in need of hospital-based care as described in OAR 309-091-0035.

1.19 "Records" refers to all financial records, other records, books, documents, papers, plans, records of shipments and payments and writings of Provider whether in paper, electronic or other form, that are pertinent to this Agreement.

1.20 "Recovery" shall mean a process of change through which Individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

1.21 "Recovery Plan" shall mean a written document created by the Individual and facilitated by a Peer Support Specialist, or an alternative as determined by the Individual, to help identify the Individual's strengths (e.g. knowledge gained from dealing with adversity, personal or professional roles, talents, personal traits) that can act as resources to the Individual and the Individual's recovery planning team in pursuing personal and treatment goals.

1.22 "Serious and Persistent Mental Illness (SPMI)" shall mean the current DSM 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.

1.23 "Supported Housing" shall mean permanent housing with tenancy rights and support services that enables Individuals to attain and maintain integrated affordable housing. Support services offered to Individuals living in supported housing are flexible and are available as needed and desired, but are not mandated as a condition of obtaining tenancy. Tenants have a private and secure place to make their home, just like other members of the community, with the same rights and responsibilities. Supported housing enables Individuals with disabilities to interact with individuals without disabilities to the fullest extent possible. Supported housing is scattered site housing. To

be considered supported housing under this Plan, for buildings with two or three units, no more than one unit may be used to provide supported housing for tenants with SPMI who are referred by Health Plan or its Providers, and for buildings or complexes with four or more units, no more than 25% of the units in a building or complex may be used to provide supported housing for tenants with SPMI who are referred by Health Plan or its Providers. Supported housing has no more than two Individuals in a given apartment or house, with a private bedroom for each Individual. If two people are living together in an apartment or house, the Individuals must be able to select their own roommates. Supported housing does not include housing where providers can reject Individuals for placement due to medical needs or substance abuse history.

1.24 "Voluntary by Guardian" shall mean that an Individual's legal guardian has signed consent for admission to an acute psychiatric facility, Oregon State Hospital, or licensed residential facility.

2. **Service Description.**

2.1 Provider shall provide oversight and care coordination for Adults with Serious and Persistent Mental Illness (SPMI) as follows:

a. Facilitate access to quality individualized community-based services and supports so that adults with SPMI are served in the most integrated setting possible; and

b. Facilitate effective utilization of services and facility-based care in the community; and

2.2 Identify anticipated capacity needs across the system and communicate with Coordinated Care Organizations (CCO), Community Mental Health Programs (CMHP), and Oregon Health Authority (OHA).

2.3 The Provider's service area shall align primarily with the Home CCO and when no CCO is identified or the Home CCO has multiple Choice Providers, then the service area will align with the County of Responsibility (COR) as follows:

a. Home CCO is the designated service area for Individuals who are:

i. CCO enrolled members; or

ii. CCO members at the time of referral to Oregon State Hospital (OSH); or

b. COR is the designated service area for Individuals who are:

i. Fee-For-Service Medicaid Eligible;

ii. Uninsured, underinsured, not eligible for Medicaid, or have exhausted Medicaid services, including those who meet the criteria for the Citizen Alien Waived Medical Program;

iii. Undocumented;

iv. Privately insured;

v. Funded through Veterans Administration; or

vi. Other as approved by OHA.

2.4 Service Population

Individuals who meet the following criteria shall be enrolled in Choice Model Services:

a. Have been civilly committed and admitted to OSH under ORS Chapter 426;

b. Have been civilly committed under ORS Chapter 426 and are referred to or at risk of being referred to OSH;

c. Admitted to OSH under guardian authorization; secured or non-secure licensed residential facility as defined in ORS 443.400 including licensed programs designated specifically for young adults in transition;

d. Are residing in a license adult foster home as defined in ORS 443.705 due to SPMI; or

e. As directed by OHA.

2.5 Individuals who, due to SPMI, meet the following criteria may be enrolled, per Provider's policies and procedures in Choice Model Services:

a. Are placed on outpatient commitment pursuant to ORS 426.127;

b. Are placed in assisted outpatient treatment pursuant to ORS 426.133;

c. Have transitioned from civil commitment pursuant to ORS 426.060 within the past 12 months;

d. Have been found to lack fitness to proceed pursuant to ORS 161.370;

e. Will end jurisdiction within the next six months or ended jurisdiction under the Psychiatric Security Review Board (PSRB) within the past 12 months;

f. Have been determined service eligible through the Department of Human Services (DHS), Aging & People with Disabilities (APD) and Intellectual/Developmental Disabilities (I/DD) Divisions to support the behavioral health service needs of Individuals determined service eligible for APD or I/DD; or

g. Are at risk of meeting the above criteria without supports offered through Choice Model Services.

2.6 Eligible Services

a. Exceptional Needs Care Coordination as appropriate to the needs, preferences, and choices of each Individual.

b. Coordination of behavioral health treatment services and supports not funded through other sources including, but not limited to:

i. Medicaid;

ii. Medicare;

iii. County Financial Assistance Agreements; or

iv. Coordinated Care Organization Contracts.

c. Activities to remove barriers and facilitate access to integrated services and supports, which are not funded through other sources. Especially when Individuals are being discharged from OSH and when establishing residence in Supported Housing. These activities may include, but are not limited to:

i. Room and board payments;

ii. Rental assistance, security deposits, and application fees;

iii. Utility payments and deposits;

iv. Prescription or over-the-counter medications and medical supplies not covered by Medicaid or other sources;

v. Transportation;

vi. Activities to secure and maintain Guardianship Services, including but not limited to:

a. Paying the costs of:

i. Court hearings to determine the necessity, continuation or termination of a guardianship.

ii. Guardianship services to make decisions related to overseeing the care and supervision of an Individual.

b. If guardianship is expected to continue beyond a transitional period of time (6 months or less) then other payment options should be sought in order to maintain guardianship services;

vii. Activities to secure and maintain representative payee services; or

viii. Peer Delivered Services.

d. Support CCO Care Coordination efforts to gather documents such as the Community Questionnaire, develop a preliminary discharge plan from OSH and sign for final authorization for the Long-Term Psychiatric Care referral.

e. Other services and supports necessary to facilitate provision of services in the most integrated setting and the prevention of admission to higher levels of care.

3. **Performance Requirements.**

Provider shall perform the following services:

3.1 Exceptional Needs Care Coordination for Individuals enrolled in Choice Model Services to facilitate access to services in the most integrated setting appropriate to the Individual's needs and strengths, including:

a. Care coordination and Discharge Planning for Individuals receiving services in licensed residential programs, even when placed outside the Provider's service area;

b. Facilitate access to community-based rehabilitative mental health treatment services that are recovery-oriented, culturally responsive, and geographically accessible;

c. Facilitate access to peer delivered services;

d. Serve as the Single Point of Contact (SPOC) for all referrals from OSH to Assertive Community Treatment as described in OAR 309-019-025 (25) Definition of SPOC in ACT Admission Process 309-019-0248;

e. Collaborate with CCO Care Coordination concerning Acute Care Psychiatric Hospitals to divert Individuals approved for LTPC from admission to OSH and toward community-based services and supports, when indicated to be appropriate;

f. Collaborate with the Department of Human Services (DSH), Aging & People with Disabilities (APD) and Intellectual/Developmental Disabilities (I/DD) Divisions to

support the behavioral health service needs of Individuals determined service eligible for APD or I/DD;

g. Coordinate the transition from forensic services for Individuals ending jurisdiction under the Psychiatric Security Review Board within six months and who will be enrolled in Choice Model Services;

h. Coordinate the transition from forensic services for Individuals found to lack fitness to proceed pursuant to ORS 161.370 and who will be enrolled in Choice Model Services; and

i. Serve as a resource for community partners and service agencies in locating local community-based behavioral health treatment services and supports.

3.2 In collaboration with CCO Care Coordinators, facilitate transition for adults with SPMI out of hospital settings into the most integrated community settings by completing the following:

a. Provider will hold a face-to-face meeting with each individual within the Provider's service area being referred to OSH from Acute Care Psychiatric Hospitals prior to being referred but no later than seventy-two (72) hours from the date of approval for LTPC to identify services, and facilitate access to those services and supports in order to divert Individuals from admission to OSH whenever possible.

b. Provider will hold a face-to-face meeting with each Individual within the Provider's service area who is civilly committed, and to the extent practical for Voluntary by Guardian, admitted to OSH within seven (7) calendar days of admission.

c. Provider will participate in OSH IDT meeting for each Individual within the Provider's service area to update the Discharge Plan and to coordinate appropriate community-based services and supports.

d. Provider will arrange, advocate and coordinate appropriate In-Reach Services from CCOs and community providers who are delegated or identified as having responsibility for providing mental health services upon discharge.

e. Provider will facilitate development of a person-centered Discharge Plan within ten (10) calendar days of admission to OSH and update the plan as appropriate after each IDT or discharge planning meeting with the Individual.

f. Provider will coordinate and facilitate access to community-based resources of those civilly committed at OSH to support discharge from OSH within seventy-two (72) hours of being determined RTT whenever possible for Individuals with SPMI who have been civilly committed ensuring that:

   i. No less than 90% of Individuals shall be discharged within twenty (20) calendar days of being determined RTT.

   ii. If not discharged within the above timeframe then each Individual shall be discharged no later than sixty (60) calendar days from the date placed on RTT.

g. Provider will collaborate with OSH to verify that entitlement enrollments (e.g. Medicaid, Medicare, SSI/SSDI) are in place and active upon discharge.

h. For Individuals not enrolled in Choice Model Services, Provider will collaborate and serve as a resource to support Discharge Planning for Individuals:

i. Determined services eligible for APD or I/DD;

ii. Under the jurisdiction of ORS 161.370 to determine fitness to proceed; or

iii. Under the jurisdiction of the Psychiatric Security Review Board.

3.3 Transition Planning and Management.

a. Provider and Health Plan will collaborate to ensure utilization management of existing residential resources;

b. Provider and Health Plan will collaborate to ensure residential treatment coordination occurs to assist both non-Medicaid and Medicaid enrolled individuals who are not enrolled in managed care in transitioning between licensed facilities and from licensed facilities to independent living; and

c. Provider and Health Plan will collaborate to provide OHA with admission and discharge information for both non-Medicaid and Medicaid enrolled individuals who are not enrolled in managed care receiving personal care and rehabilitative mental health services in licensed community-based settings.

3.4 Develop and promote Peer Run and Peer Delivered Services.

a. Peer run and peer delivered services are provided by individuals who have successfully engaged in their own personal recovery and demonstrate the core competencies for Peer Support Specialists, as defined by OAR 410-180- 0300 through 410-180-0380, which may be revised from time to time;

b. Peer Support Specialists are compensated for delivering Peer Delivered Services;

c. The provider shall maintain policies and procedures that facilitate and document accessibility to a full range of peer run and peer delivered services;

d. Ensure each individual reported to OHA as an MHS 37 - Choice Model Services recipient has an individualized recovery plan subject to recipient choice; and

e. Match individuals with peers who are best suited to assist in achieving goals in the individualized recovery plan. These services are provided by individuals who share a similar experience and promote recovery.

3.5 Recovery-oriented services.

a. Develop recovery oriented services based on identified individual and community needs that are culturally responsive and geographically accessible; and

b. Develop purchasing strategies that encourage consumer self-direction, including but not limited to, developing voucher payment methods for some services.

3.6 Guardianship, conservator and/or payee.

a. Provider may establish criteria for financially supporting guardianship; and

b. Provider may prioritize support of court costs to establish non-paid family member as guardian.

3.7 Supportive and Supported Employment.

Choice Model payments may be used to purchase services and for system development as mutually agreed upon between Health Plan and Provider as prescribed in Choice Model

Services procedures located at https://www.oregon.gov/oha/HSD/AMH/Pages/Choice-Model.aspx?wp3656=p:1&wp8654=p:1#g_8bd821e7_6e2e_4f47_b279_1a2ab30189af, as it may be revised from time to time.

4. **Monitoring and Administrative Functions.**

Provider shall perform the following monitoring and administrative functions:

4.1 Monitor the Choice Model Services Client outcomes, service access and utilization;

4.2 Analyze and prepare the Choice Model Services performance reports, which include outcomes, access and utilization;

4.3 Distribute and review reports with Provider management, Provider staff and Health Plan;

4.4 Document, track and report all qualifying events which justify performance payments as described in this Agreement;

4.5 Document and track individual's level of care movement against established benchmarks and performance standards to ensure clients are transitioning toward independent living;

4.6 Track outcomes, access and service utilization patterns and uses data to drive service delivery improvements;

4.7 Use reports and data to drive improvement processes at all levels; and

4.8 Submit all reports as directed within this Agreement which are complete and accurate within the prescribed time frames.

5. **Designating a Lead.**

Provider shall designate a staff person as the Choice Model Services Lead ("Lead"). Health Plan shall contact the Lead for all matters related to the work performed by Provider under this agreement.

The Lead shall:

5.1 Using the definition of the Choice Model Services target population, review medical record documentation, Level of Care Utilization System (LOCUS) results and other source materials to evaluate whether the Choice Model Services criteria is met and determines if each referral will be accepted into Choice Model Services and when clients will be discharged;

5.2 Receive and monitor RTT and ADP OSH reports;

5.3 Ensure the administration of the Level of Care Utilization System (LOCUS) at specified intervals and/or when clinical indicated as the client progresses through the continuum of care and ensure LOCUS supports individual's current Level of Care (LOC) placement within the continuum of care;

5.4 Perform care coordination, transitional planning and management which facilitates timely access to services and supports consistent with clinical needs of the client, and the Choice Model Services which includes monitoring utilization of the target population;

5.5 Coordinate local treatment planning team meetings and develop a plan which ensures a smooth and rapid transition to a lower level of care for clients in the service area temporarily residing at OSH;

5.6 Assure Provider is represented at all IDT meetings and ensure appropriate community based services and supports are developed and available prior to and upon IDT determination that the client no longer requires hospital level of services;

5.7 Coordinate all individual placements, receive and review clinical packets from OSH and make appropriate LOC referrals ensuring timely transfer of information required for placement;

5.8 Contact other Choice Model Services Leads throughout the state to facilitate placements when regional resources are not available;

5.9 Systemically monitor individual needs and provide assistance to ensure individuals have access to and obtain services, resources, and appropriate benefits in support of an individualized recovery processes;

5.10 Perform utilization management of existing residential resources by coordinating and tracking client transitions between licensed facilities, and from licensed facilities to independent living;

5.11 Work with providers to ensure clients are receiving recovery-oriented, culturally responsive, and geographically accessible services and supports which promote autonomy, community integration and independent living; and

5.12 Attend all Choice Model Services meetings hosted by Health Plan and disseminate information appropriately.

6. **Special Reporting Requirements.**

6.1 Provider shall prepare and electronically submit to Health Plan the following written reports using forms and procedures as prescribed on OHA's website, located at https://www.oregon.gov/OHA/HSD/AMH/Pages/Reporting-Requirements.aspx:

a. Maintain for reference but not submit policies and procedures for enrollment in Choice Model Services.

b. Monthly invoice specifying eligible expenditures for services and supports to eligible individuals shall be submitted no later than the fifth day of the month after a period following the reporting subject month (i.e. January's report would submitted to PacificSource on March 5th). Date range of the invoice time period must be specified on each invoice.

c. Monthly Choice Model Client Status Reports shall be submitted no later than the fifth day of the month after a period following the reporting subject month (i.e. January's report would submitted to PacificSource on March 5th) during the term of the Agreement for review and approval.

d. Any other reports as mutually agreed upon between OHA, Health Plan, and the Provider.

6.2 Upon Health Plan's identification of any deficiencies in the Provider's performance under this Agreement, including failure to submit reports as required, failure to expend available funding, or failure to meet performance requirements, Provider shall prepare and submit to Health Plan within 30 calendar days a Corrective Action Plan (CAP) to be reviewed and approved by Health Plan. The CAP must 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 Health Plan; and

d. Proposed remedies, short of termination, should Provider not come into compliance within the timeframe set forth in the CAP.

6.3 Provider shall submit the reports required under this Agreement via the PacificSource ShareFile platform.

Email: Hannah.tacke@pacificsource.com

Reports must be prepared using forms provided by the CCO Behavioral Health Clinical Quality Improvement Team.

7. **Responsibilities of Health Plan.**

Health Plan shall perform the following duties for the Choice Model Services program:

7.1 Interface with OHA Health Systems Division regarding Choice Model Services Agreement administration, planning, development, performance, payment or other issues as deemed necessary and appropriate by Health Plan, in its sole discretion;

7.2 Process payments received, and review, prepare and submit all Choice Model Services financial reports to OHA Health Systems Division;

7.3 Monitor Provider's performance to ensure all reports are accurate, complete and submitted within required timeframes and that performance standards are met;

7.4 Provide technical assistance as it relates to quality assurance and meeting performance requirements; and

7.5 Ensure corrective action plans are developed and submitted to OHA as needed which includes enforcement and tracking of corrective action plans through to resolution.

8. **Payment Calculation, Disbursement, and Settlement Procedures.**

8.1 Disbursement of Payment: Provider agrees to submit monthly invoices no later than the fifth day of the month after a period following the reporting subject month (i.e. January's report would submitted to PacificSource on March 5th) for work performed on or after effective date and on or before termination date. Provider will be reimbursed by Health Plan via direct deposit within 30 (thirty) business days of monthly invoice submission. Annual payment for Choice Model Services shall be capped at: $407,889.02 for contract period January 1, 2022 through December 31, 2022. A performance payment of $11,181.17 for the time frame of January 1, 2022 through June 30, 2022 and a performance payment of $11,181.17 for the time frame of July 1, 2022 through December 31, 2022 may be available if the applicable conditions described below are achieved for the entire region Health Plan's Choice Model contract covers. Refer to attached Table 1.

8.2 Calculation of Performance Payment: Contractor will qualify for a performance payment at the end of the calendar year if it was operational, as defined by serving Individuals for a minimum of 180 calendar days per fiscal year and who submit the Monthly Choice Model Client Status Report no later than the fifth day of the month after a period following the reporting subject month (i.e. January's report would submitted to PacificSource on March 5th) during the term of the contract and address any deficiencies identified by the Contract Administrator. All reports shall be submitted in accordance with the "Reporting Requirements" section above.

8.3 Disbursement of Carry-Over Funds. In the event there are undisbursed Choice Model Services funds from previous agreement periods, such funds will be disbursed based upon Provider invoice and brief description of proposed use of carry-over funds in addition to monthly Choice Model payments under this Agreement. Health Plan will evaluate proposals to assure compliance with the stated purpose of this Agreement and any other guidance from OHA for use of these funds.

8.4 Disbursement of Performance Payment. The performance payment is based on achievement of the performance criteria as prescribed in OHA's website located at http://www.oregon.gov/oha/HPA/CSI-BHP/Pages/Oregon-Performance-Plan.aspx. Upon Health Plan's determination that Provider met or exceeded the performance criteria, Health Plan will request funds from OHA and distribute to Provider within 30 (thirty) days of receiving funds from OHA. The Performance Payment is only dispersed if both Central Oregon and the Columbia Gorge regions have met the criteria as outlined in 8.3.

8.5 Agreement Settlement. Agreement Settlement will be used to confirm implementation of the project described herein based on data properly reported. Payments will be recovered for unconfirmed services, as noted by incomplete or missing reporting requirements, as percentage of the payment made for that subject reporting period. There is no Settlement on Performance Payments.

9. **Attachments.**

The following attachments are incorporated herein and made a part hereof by this reference: Attachment A – Special Provisions; Attachment B – Standard Terms and Conditions; and Attachment C – Insurance Requirements.

IN WITNESS WHEREOF, the Parties have executed this Agreement by and through their duly authorized representatives.

PACIFICSOURCE COMMUNITY SOLUTIONS		DESCHUTES COUNTY HEALTH SERVICES	
By:	_____	By:	_____ (Signature)
	_Peter McGarry_____		_____ (Print or type name)
Title:	_Vice President – Provider Network_	Title:	_____
Date:	_____	Date:	_____
Address:	PO Box 7469 Bend, OR 97708	Address:	

Table 1

Deschutes County Health Services	
Payment Period January 1, 2022 through June 30, 2022	Not to exceed: $203,944.91
Payment Period July 1, 2022 through December 31, 2022	Not to exceed: $203,944.91
Eligible Performance Payment January 1, 2022 through June 30, 2022	$11,181.17
Eligible Performance Payment July 1, 2022 through December 31, 2022	$11,181.17
Performance payment is received only if all regions meet the required performance measure in Section 8.3 of the Choice Model Services Agreement.	

ATTACHMENT A

Special Provisions
Effective 01/01/2022

1. **Confidential Information:**

1.1 Client Information.

a. All information as to personal facts and circumstances obtained by the Provider on the client ("Client Information") shall be treated as privileged communications, shall be held confidential, and shall not be divulged without the written consent of the client, his or her guardian, or the responsible parent when the client is a minor child, or except as required by other terms of this Agreement. Nothing prohibits the disclosure of information in summaries, statistical, or other form, which does not identify particular individuals.

b. The use or disclosure of Client Information shall be limited to persons directly connected with the administration of this Agreement. Confidentiality policies shall be applied to all requests from outside sources.

c. If Provider, or any of its officers, directors, employees, agents, or subcontractors receives or has access to confidential Social Security Administration (SSA) or Federal Tax Information (FTI) records in the performance of Services under this Agreement, Provider shall comply, and ensure that all of Provider's officers, directors, employees, agents and subcontractors comply, with the following provisions:

i. With respect to SSA records:

A. Provide a current list of employees and employees of any agent or subcontractor with access to SSA records;

B. Adhere to the same security requirements as employees of OHA.

C. Abide by all relevant Federal Law, restrictions on access, use, disclosure, and the security requirements contained within OHA's agreement with SSA;

D. Provide its employees and agents the same security awareness training as OHA's employees; and

E. Include the provisions of this Section 1.1(c)(i) in any subcontract related to this Agreement.

ii. With respect to Federal Tax Information (FTI), as defined in IRS Publication 1075;

A. Provider and its officers, directors, and employees with access to, or who use FTI provided by OHA must meet the background check requirements defined in IRS Publication 1075;

B. Any FTI made available to Provider shall be used only for the purpose of carrying out the provisions of this Agreement. Provider shall treat all information contained in FTI as confidential and that information shall not be divulged or made known in any manner to any person except as may be necessary in the performance of this Agreement. Inspection by or disclosure to anyone other than an officer or employee of Provider is prohibited;

C. Provider shall account for all FTI upon receipt and shall properly store all FTI before, during, and after processing. In addition, all FTI related output and products will be given the same level of protection as required for the source material;

D. No work involving FTI furnished under this Agreement will be subcontracted without prior written approval of the IRS;

E. Maintain a list of employees who are authorized access to FTI. Such list will be provided to OHA and, upon request, to the IRS reviewing office; and

F. Include the provisions of this Section 1.1(c)(ii) in any subcontract related to this Agreement.

iii. Failure to abide by any of the requirements in this subsection could result in criminal or civil penalties and result in termination of this Agreement.

iv. Provider may be subject to periodic and ongoing security reviews to ensure compliance with the requirements of Section 1.1(c).

d. Except as prohibited by Section 1.1(c) above, OHA, Health Plan, Provider and any subcontractor will share information as necessary to effectively serve Health Plan clients.

1.2 Non-Client Information.

a. Each Party acknowledges that it and any of its officers, directors, employees and agents may, in the course of performing its responsibilities under the Agreement, be exposed to or acquire information that is confidential to the other Party. To the extent permitted by law, any and all information of any form provided to a Party or its officers, directors, employees and agents in the performance of the Agreement that reasonably could at the time of its disclosure be understood to be confidential shall be deemed to be confidential information of the originating Party ("Confidential Non-Client Information").

b. Confidential Non-Client Information shall be deemed not to include information that:

i. Is or becomes (other than by disclosure by the Party acquiring such information) publicly known or is contained in a publicly available document except to the extent applicable law still restricts disclosure;

ii. Is furnished by the originating Party to others without restrictions similar to those imposed on the receiving Party under the Agreement;

iii. Is rightfully in the receiving Party's possession without the obligation of nondisclosure prior to the time of its disclosure by the originating Party under the Agreement;

iv. Is obtained from a source other than the originating Party without the obligation of confidentiality;

v. Is disclosed with the written consent of the originating Party; or

vi. Is independently developed by the receiving Party's officers, directors, employees and agents who can be shown to have had no access to the Confidential Non-Client Information.

1.3 Nondisclosure. The receiving Party shall hold all Confidential Non-Client Information in strict confidence, using at least the same degree of care that it uses in maintaining the confidentiality of its own confidential information; shall not sell, assign, license, market, transfer or otherwise dispose of, give or disclose Confidential Non-Client Information to third parties; shall not use Confidential Non-Client Information for any purposes whatsoever other than as contemplated by this Agreement or reasonably related thereto; and shall advise any of its officers, directors, employees and agents that receive or have access to the Confidential Non-Client Information of their obligations to keep Confidential Non-Client Information confidential. These confidentiality obligations do not restrict disclosure of information otherwise qualifying as Confidential Non-Client Information if the receiving Party can show that either of the following conditions exists: (i) the information was disclosed in response to a subpoena or court order duly issued in a judicial or legislative process, in which case the receiving Party shall notify the originating Party of the subpoena five days prior to the disclosure, unless such notice could not reasonably be given; or (ii) the disclosure was required to respond to a request for the information made under the Oregon Public Records Law, ORS 192.410 to 192.505. The receiving Party shall notify the originating Party of a public records request five days prior to the disclosure.

a. Upon request and pursuant to the instructions of Health Plan, Provider shall return or destroy all copies of Confidential Information, and Provider shall certify in writing the return or destruction of all Confidential Information.

b. "Client" means any individual, family or Provider:

i. For whom an Agency must provide Services and incidental or specialized Goods, in any combination thereof ("Services and Incidental Supplies"), according to state, federal law, rule, and policy. Those Services and Incidental Supplies include but are not limited to treatment, care, protection, and support without regard to the proximity of the services being provided;

ii. Who in fact receives and utilizes services provided by an Agency primarily for that individual's or family's benefit;

iii. Who is under the custody, care, or both of the Agency; or

iv. Who provides direct care or Services and is a proxy or representative of the non-Provider Client.

2. **Amendments.**

2.1 Health Plan reserves the right to amend or extend the Agreement under the following general circumstances:

1.1 Health Plan may extend the Agreement for additional periods of time up to a total Agreement period of 5 (five) years, and for additional money associated with the extended period(s) of time. The determination for any extension for time may be based on Health Plan's satisfaction with performance of the work or services provided by the Provider under this Agreement.

2.1 Health Plan may periodically amend any payment rates throughout the life of the Agreement proportionate to increases in Portland Metropolitan Consumer Price Index; and to provide Cost Of Living Adjustments (COLA) if Health Plan so chooses. Any negation of increases in rates to implement a COLA will be as directed by the Oregon State Legislature.

2.2 Health Plan further reserves the right to amend the Statement of Work for the following:

1.1 Programmatic changes, additions, or modifications deemed necessary to accurately reflect the original scope of work that may not have been expressed in the original Agreement or previous amendments to the Agreement;

2.1 Implement additional phases of the Work; or

3.1 As necessitated by changes in Code of Federal Regulations, Oregon Revised Statutes, or Oregon Administrative Rules which, in part or in combination, govern the provision of services provided under this Agreement.

2.3 Upon identification, by any party to this Agreement, of any circumstance which may require an amendment to this Agreement, the parties may enter into negotiations regarding the proposed modifications. Any resulting amendment must be in writing and be signed by all parties to the Agreement before the modified or additional provisions are binding on either party. All amendments must comply with the "Amendments; Waiver; Consent" provision of this Agreement.

3. **Provider Requirements to Report Abuse of Certain Classes of Persons.**

3.1 Provider shall comply with, and cause its employees, agents and subcontractors to comply with, the applicable laws for mandatory reporting of abuse including but not limited to abuse of the following classes of persons in Oregon:

1.1 Children (ORS 419B.005 through 419B.045);

2.1 Elderly Persons (ORS 124.055 through 124.065);

3.1 Residents of Long Term Care Facilities (ORS 441.630 through 441.645); and

4.1 Adults with Mental Illness or Developmental Disabilities (ORS 430.735 through 430.743).

3.2 In addition to the requirements of Section 3.1., if law enforcement is notified regarding a report of child abuse, Provider shall also notify the local Child Protective Services Office of the Department of Human Services within 24 (twenty-four) hours. If law enforcement is notified regarding a report of abuse of elderly, long term care facility residents, adults with mental illness or developmental disabilities, the Provider shall also notify the local Aging and People with Disabilities Office of the Department of Human Services within 24 (twenty-four) hours.

3.3 If known, the abuse report should contain the following:

a. The name and address of the abused person and any persons responsible for that person's care;

b. The abused person's age;

c. The nature and extent of the abuse, including any evidence of previous abuse;

d. The explanation given for abuse;

e. The date of the incident; and

f. Any other information that might be helpful in establishing the cause of the abuse and the identity of the abuser.

ATTACHMENT B

Standard Terms and Conditions
Effective 01/01/2022

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 Health Plan or any other agency or department of the State of Oregon, or both, and Provider that arises from or relates to this Agreement shall be brought and conducted solely and exclusively within the Circuit Court of Marion County for the State of Oregon; provided, however, if a Claim must be brought in a federal forum, then it shall be brought and conducted solely and exclusively within the United States District Court for the District of Oregon. Each party hereby consents to the exclusive jurisdiction of such court, waives any objection to venue, and waives any claim that such forum is an inconvenient forum. This Section shall survive expiration or termination of this Agreement.

2. **Compliance with Law.**

Provider shall comply and cause all subcontractors to comply with all federal, state and local laws, regulations, executive orders and ordinances applicable to this Agreement. Health Plan's performance under the Agreement is conditioned upon Provider's compliance with the obligations of providers under ORS 279B.220, 279B.230 and 279B.235, which are incorporated by reference herein. This Section shall survive expiration or termination of this Agreement.

3. **Independent Provider.**

3.1 Provider is not an officer, employee, or agent of the State of Oregon as those terms are used in ORS 30.265 or otherwise.

3.2 If Provider is currently performing work for the State of Oregon or the federal government, Provider by signature to this Agreement, represents and warrants that Provider's Services to be performed under this Agreement creates no potential or conflict of interest as defined by ORS Chapter 244 and that no statutes, rules or regulations of the State of Oregon or federal agency for which Provider currently performs work would prohibit Provider's services under this Agreement. If compensation under this Agreement is to be charged against federal funds, Provider certifies that it is not currently employed by the federal government.

3.3 Provider is responsible for all federal and state taxes applicable to compensation paid to Provider under this Agreement and, unless Provider is subject to backup withholding, Health Plan will not withhold from such compensation any amounts to cover Provider's federal or state tax obligations. Provider is not eligible for any social security, unemployment insurance or workers' compensation benefits from compensation paid to Provider under this Agreement, except as a self-employed individual.

3.4 Provider shall perform all Services under this Agreement as an Independent Provider, as defined in ORS 670.600. Health Plan reserves the right (i) to determine and modify the delivery schedule for the Services and (ii) to evaluate the quality of the Services, however, Health Plan may not and will not control the means or manner of Provider's performance. Provider is responsible for determining the appropriate means and manner of performing the Services

4. **Representations and Warranties.**

4.1 Provider's Representations and Warranties. Provider represents and warrants to Health Plan that:

a. Provider 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 in a professional manner and in accordance with standards prevalent in Provider's industry, trade or profession;

d. Provider shall, at all times during the term of this Agreement, be qualified, professionally competent, and duly licensed to perform the Work; and

e. Provider prepared its proposal related to this Agreement, if any, independently from all other proposers, and without collusion, fraud, or other dishonesty.

4.2 Warranties Cumulative. The warranties set forth in this section are in addition to, and not in lieu of, any other warranties provided.

5. **Time is of the Essence.**

Provider agrees that time is of the essence under this Agreement.

6. **Funds available and Authorized; Payments.**

6.1 Provider shall not be compensated for Work performed under this Agreement by any other agency or department of the State of Oregon or the federal government. Provider understands and agrees that Health Plan's payment for Work performed is contingent on Health Plan receiving funding from OHA.

6.2 **Payment Method.** Payments under this Agreement will be made by Electronic Funds Transfer (EFT) and shall be processed in accordance with the provisions of OAR 407-120-0100 through 407-120-0380 or OAR 410-120-1260 through OAR 410-120-1460, as applicable, and any other OHA Oregon Administrative Rules that are program-specific to the billings and payments. Upon request, Provider shall provide its taxpayer identification number (TIN) and other necessary banking information to receive EFT payment. Provider shall maintain at its own expense a single financial institution or authorized payment agent capable of receiving and processing EFT using the Automated Clearing House (ACH) transfer method. The most current designation and EFT information will be used for all payments under this Agreement. Provider shall provide this designation and information on a form provided by Health

Plan. In the event that EFT information changes or the Provider elects to designate a different financial institution for the receipt of any payment made using EFT procedures, the Provider shall provide the changed information or designation to Health Plan on a Health Plan-approved form. Health Plan is not required to make any payment under this Agreement until receipt of the correct EFT designation and payment information from the Provider.

7. **Recovery of Overpayments.**

If billings under this Agreement, or under any other Agreement between Provider and Health Plan, result in payments to Provider to which Provider is not entitled, Health Plan, after giving written notification to Provider may withhold from payments due to Provider such amounts, over such periods of time, as are necessary to recover the amount of the overpayment unless Provider provides a written objection within fourteen (14) calendar days from the date of the notice. Absent timely written objection, Provider hereby reassigns to Health Plan any right Provider may have to receive such payments. If Provider provides a timely written objection to Health Plan's withholding of such payments, the Parties agree to confer in good faith regarding the nature and amount of the overpayment in dispute and the manner in which the overpayment is to be repaid. Health Plan reserves the right to pursue any or all of the remedies available to it under this Agreement and at law or in equity including Health Plan's right to setoff.

8. **Ownership of Work Product.**

8.1 **Definitions.** As used in this Section 8, and elsewhere in this Agreement, the following terms have the meanings set forth below:

a. "Provider Intellectual Property" means any intellectual property owned by Provider and developed independently from the Work.

b. "Third Party Intellectual Property" means any intellectual property owned by parties other than Health Plan or Provider.

c. "Work Product" means every invention, discovery, work of authorship, trade secret or other tangible or intangible item and all intellectual property rights therein that Provider is required to deliver to Health Plan pursuant to the Work.

8.2 **Original Works.** All Work Product created by Provider pursuant to the Work, including derivative works and compilations, and whether or not such Work Product is considered a "work made for hire," shall be the exclusive property of Health Plan. Health Plan and Provider agree that all Work Product is "work made for hire" of which Health Plan is the author within the meaning of the United States Copyright Act. If for any reason the original Work Product created pursuant to the Work is not "work made for hire," Provider hereby irrevocably assigns to Health Plan any and all of its rights, title, and interest in all original Work Product created pursuant to the Work, whether arising from copyright, patent, trademark, trade secret, or any other state or federal intellectual property law or doctrine. Upon Health Plan's reasonable request, Provider shall execute such further documents and instruments necessary to fully vest such rights in Health Plan. Provider forever waives any and all rights relating to original Work Product created pursuant to the Work, including without

limitation, any and all rights arising under 17 U.S.C. §106A or any other rights of identification of authorship or rights of approval, restriction or limitation on use or subsequent modifications.

a. In the event that Work Product is Provider Intellectual Property, a derivative work based on Provider Intellectual Property or a compilation that includes Provider Intellectual Property, Provider hereby grants to Health Plan an irrevocable, non-exclusive, perpetual, royalty-free license to use, reproduce, prepare derivative works based upon, distribute copies of, perform and display Provider Intellectual Property and the pre-existing elements of the Provider Intellectual Property employed in the Work Product, and to authorize others to do the same on Health Plan's behalf.

b. In the event that Work Product is Third Party Intellectual Property, a derivative work based on Third Party Intellectual Property or a compilation that includes Third Party Intellectual Property, Provider shall secure on Health Plan's behalf and in the name of Health Plan an irrevocable, non-exclusive, perpetual, royalty-free license to use, reproduce, prepare derivative works based upon, distribute copies of, perform and display the Third Party Intellectual Property and the pre-existing elements of the Third Party Intellectual Property employed in the Work Product, and to authorize others to do the same on Health Plan's behalf.

9. **Indemnity.**

9.1 **Provider** shall defend (subject to ORS chapter 180), save, hold harmless, and indemnify the State of Oregon and Health Plan and their officers, employees and agents from and against all claims, suits, actions, losses, damages, liabilities, costs and expenses of any nature whatsoever, including attorney's fees, resulting from, arising out of, or relating to the activities of Provider or its officers, employees, sub-providers, or agents under this Agreement.

9.2 **Indemnity for Infringement Claims.** Without limiting the generality of section 9.a., Provider expressly agrees to defend, indemnify, and hold Health Plan, OHA, and the State of Oregon and their agencies, subdivisions, officers, directors, agents, and employees harmless from any and all claims, suites, actions, losses, liabilities, costs, expenses, including attorney's fees, and damages arising out of or related to any claims that the work, the work product, or any other tangible or intangible items delivered to Health Plan or OHA by Provider that may be the subject of protection under any State or Federal intellectual property law or doctrine, or Health Plan or OHA's use thereof, infringes any patent, copyright, trade secret, trademark, trade dress, mask work, utility design, or other proprietary right of any third party; provided, that the indemnified party shall provide Provider with prompt written notice of any infringement claim.

THIS SECTION SHALL SURVIVE EXPIRATION OR TERMINATION OF THIS AGREEMENT.

10. **Default; Remedies; Termination.**

10.1 **Default by Provider.** Provider shall be in default under this Agreement if:

a. Provider institutes or has instituted against it insolvency, receivership or bankruptcy proceedings, makes an assignment for the benefit of creditors, or ceases doing business on a regular basis; or

b. Provider no longer holds a license or certificate that is required for Provider to perform its obligations under the Agreement and Provider has not obtained such license or certificate within 14 (fourteen) calendar days after Health Plan's notice or such longer period as Health Plan may specify in such notice; or

c. Provider commits any material breach or default of any covenant, warranty, obligation or agreement under this Agreement, fails to perform the Work under this Agreement within the time specified herein or any extension thereof, or so fails to pursue the Work as to endanger Provider's performance under this Agreement in accordance with its terms, and such breach, default or failure is not cured within 14 (fourteen) calendar days after Health Plan's notice, or such longer period as Health Plan may specify in such notice.

10.2 **Health Plan's Remedies for Provider's Default.** In the event Provider is in default, Health Plan may, at its option, pursue any or all of the remedies available to it under this Agreement and at law or in equity, including, but not limited to:

a. termination of this Agreement;

b. withholding all monies due for Work and Work Products that Provider has failed to deliver within any scheduled completion dates or has performed inadequately or defectively;

c. initiation of an action or proceeding for damages, specific performance, or declaratory or injunctive relief; or

d. exercise of its right of recovery of overpayments.

These remedies are cumulative to the extent the remedies are not inconsistent, and Health Plan may pursue any remedy or remedies singly, collectively, successively or in any order whatsoever. If a court determines that Provider was not in default, then Provider shall be entitled to the same remedies as if this Agreement was terminated.

10.2 **Default by Health Plan.** Health Plan shall be in default under this Agreement if Health Plan commits any material breach or default of any covenant, warranty, or obligation under this Agreement, and such breach or default is not cured within 30 (thirty) calendar days after Provider's notice or such longer period as Provider may specify in such notice.

10.3 **Provider's Remedies for Health Plan's Default.** In the event Health Plan terminates the Agreement under Section, or in the event Health Plan is in default and whether or not Provider elects to exercise its right to terminate the Agreement, Provider's sole monetary remedy shall be (i) with respect to Work compensable at a

stated rate, a claim for unpaid invoices, time worked within any limits set forth in this Agreement but not yet invoiced, authorized expenses incurred and interest within the limits permitted under ORS 293.462, and (ii) with respect to deliverable-based Work, a claim for the sum designated for completing the deliverable multiplied by the percentage of Work completed and accepted by Health Plan, less previous amounts paid and any claim(s) that Health Plan has against Provider. In no event shall Health Plan be liable to Provider for any expenses related to termination of this Agreement or for anticipated profits. If previous amounts paid to Provider exceed the amount due to Provider under this Section, Provider shall immediately pay any excess to Health Plan upon written demand. If Provider does not immediately pay the excess, Health Plan may recover the overpayments, and may pursue any other remedy that may be available to it.

10.4 **Termination.**

At its sole discretion, Health Plan may terminate this Agreement:

a. For its convenience upon 30 (thirty) days' prior written notice by Health Plan to Provider;

b. Immediately upon written notice if Health Plan fails to receive funding, appropriations, limitations, allotments or other expenditure authority at levels sufficient to pay for the Work or Work Products; or

c. Immediately upon written notice if federal or state laws, regulations, or guidelines are modified or interpreted in such a way that Health Plan's purchase of the Work or Work Products under this Agreement is prohibited or Health Plan is prohibited from paying for such Work or Work Products from the planned funding source.

d. Immediately upon written notice to Provider if there is a threat to the health, safety, or welfare of any recipient of Services under this Agreement, including any Medicaid Eligible Individual, under its care.

10.5 **Health Plan's Right to Terminate for Cause.** In addition to any other rights and remedies Health Plan may have under this Agreement, Health Plan may terminate this Agreement immediately upon written notice to Provider, or at such later date as Health Plan may establish in such notice, if Provider is in default.

10.6 **Provider's Right to Terminate for Cause.** Provider may terminate this Agreement upon 30 (thirty) days written notice to Health Plan, or at such later date as Provider may establish in such notice, if Health Plan is in default and Health Plan fails to cure such default within 30 (thirty) calendar days after Health Plan receives Provider's notice or such longer period as Provider may specify in such notice.

10.7 **Mutual Termination.** The Agreement may be terminated immediately upon mutual written consent of the parties or at such other time as the parties may agree in the written consent.

10.8 **Return of Property.** Upon termination of this Agreement, for any reason whatsoever, Provider shall immediately deliver to Health Plan all of Health Plan's

property that is in the possession or under the control of Provider at that time. This Section survives the expiration or termination of this Agreement.

10.9 **Effect of Termination**. Upon receiving a notice of termination of this Agreement, or upon issuing a notice of termination to Health Plan, Provider shall immediately cease all activities under this Agreement, unless in a notice issued by Health Plan, Health Plan expressly directs otherwise.

10.10 **Stop-Work Order.** Health Plan may, at any time, by written notice to the Provider, require the Provider to stop all, or any part of the work required by this Agreement for a period of up to 90 days after the date of the notice, or for any further period to which the parties may agree through a duly executed amendment. Upon receipt of the notice, Provider shall immediately comply with the Stop-Work Order terms and take all necessary steps to minimize the incurrence of costs allocable to the work affected by the stop work order notice. Within a period of 90 days after issuance of the written notice, or within any extension of that period to which the parties have agreed, Health Plan shall either:

a. Cancel or modify the stop work order by a supplementary written notice; or

b. Terminate the work as permitted by either the Default or the Convenience provisions.

If the Stop Work Order is canceled, Health Plan may, after receiving and evaluating a request by the Provider, make an adjustment in the time required to complete this Agreement and the Agreement price by a duly executed amendment.

11. **Limitation of Liabilities.**

Except for liability arising under or related to section 9. Indemnity, neither party shall be liable for incidental or consequential damages arising out of or related to this Agreement.

12. **Insurance.**

Provider shall maintain insurance as set forth in Attachment C.

13. **Records Maintenance, Access.**

Provider shall maintain all financial records relating to this Agreement in accordance with generally accepted accounting principles. In addition, Provider shall maintain any other records, books, documents, papers, plans, records of shipments and payments and writings of Provider, whether in paper, electronic or other form, that are pertinent to this Agreement, in such a manner as to clearly document Provider's performance. All financial records, other records, books, documents, papers, plans, records of shipments and payments and writings of Provider whether in paper, electronic or other form, that are pertinent to this Agreement, are collectively referred to as "Records." Provider acknowledges and agrees that Health Plan and the Secretary of State's Office and the federal government and their duly authorized representatives shall have access to all Records to perform examinations and audits and make excerpts and transcripts. Provider shall retain and keep accessible all Records for the longest of:

13.1 Six (6) years following final payment and termination of this Agreement;

13.2 The period as may be required by applicable law, including the records retention schedules set forth in OAR Chapter 166; or

13.3 Until the conclusion of any audit, controversy or litigation arising out of or related to this Agreement.

14. **Information Privacy/Security/Access.**

If the Work performed under this Agreement requires Provider or, when allowed, its sub Provider(s), to have access to or use of any OHA computer system or other OHA Information Asset for which OHA imposes security requirements, and OHA grants Provider or its sub Provider(s) access to such OHA Information Assets or Network and Information Systems, Provider shall comply and require all sub Provider(s) to which such access has been granted to comply with OAR 407-014-0300 through OAR 407-014-0320, 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 407-014-0305, as such rule may be revised from time to time.

15. **Force Majeure.**

No party is responsible for delay or default caused by an event beyond its reasonable control. Health Plan may terminate this Agreement upon written notice after reasonably determining the delay or default reasonably prevents performance of this Agreement.

16. **Foreign Provider.**

If Provider is not domiciled in or registered to do business in the State of Oregon, Provider shall promptly provide to the Department of Revenue and the Secretary of State Corporation Division all information required by those agencies relative to this Agreement.

17. **Subcontracts; Assignment; Successors.**

Provider shall not assign, transfer, or subcontract rights or responsibilities under this Agreement in whole or in part, without the prior written approval of Health Plan. This Agreement's provisions are binding upon and inure to the benefit of the parties to this Agreement and their respective successors and assigns.

18. **No Third Party Beneficiaries.**

Health Plan and Provider are the only parties to this Agreement and are the only parties entitled to enforce its terms. 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 Section shall survive expiration or termination of this Agreement.

19. **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. This Section shall survive expiration or termination of this Agreement.

20. **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 Provider or Health Plan at the address or number set forth in this Agreement, or to such other addresses or numbers as either party may indicate pursuant to this Section. Any communication or notice so addressed and mailed by regular mail shall be deemed received and effective five days after the date of mailing. Any communication or notice delivered by facsimile shall be deemed received and 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. Notwithstanding the foregoing, to be effective against the other party, any notice transmitted by facsimile must be confirmed by telephone notice to the other party. Any communication or notice given by personal delivery shall be deemed effective when actually delivered to the addressee.

Health Plan:
Peter McGarry
PO Box 7469
Bend, OR 97708
Telephone: 503-802-5338
Fax: 541-330-4910

Deschutes County Health Services
Kara Cronin
1128 NW Harriman St.
Bend, OR 97703
Telephone: 541-322-7526

This Section shall survive expiration or termination of this Agreement.

21. **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.

22. **Merger Clause.**

This Agreement 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.

23. **Amendments; Waiver; Consent**.

Health Plan may amend this Agreement to the extent provided herein, the solicitation document, if any from which this Agreement arose, and to the extent permitted by applicable statutes and administrative rules. No amendment, waiver, or other consent under this Agreement shall bind either party unless it is in writing and signed by both parties and when required, the Department of Justice. Such amendment, waiver, or consent shall be effective only in the specific instance and for the specific purpose given. 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. This Section shall survive the expiration or termination of this Agreement.

24. **Provider's Failure to Perform.**

Provider's failure to perform the statement of work specified in this Agreement or to meet the performance standards established in this Agreement, may result in consequences that include, but are not limited to:

24.1 Reducing or withholding payment under this Agreement;

24.2 Requiring Provider to perform at Provider's expense additional work necessary to perform the statement of work or meet performance standards; and

24.3 Declaring a default of this Agreement and pursuing any available remedies for default, including termination of the Agreement as permitted in Section 10.

ATTACHMENT C

Insurance Requirements
Effective 01/01/2022

Provider shall obtain at Provider's expense the insurance specified in this section to performing under this Agreement and shall maintain it in full force and at its own expense throughout the duration of this Agreement, as required by any extended reporting period or tail coverage requirements, and all warranty periods that apply. Provider shall obtain the following insurance from insurance companies or entities that are authorized to transact the business of insurance and issue coverage in State and that are acceptable to Health Plan, Coverage shall be primary and non-contributory with any other insurance and self-insurance. Provider shall pay for all deductibles, self-insured retention and self-insurance, if any:

1. **Workers' Compensation & Employers' Liability.**

   All employers, including Provider, that employ subject workers, as defined in ORS 656.027, shall comply with ORS 656.017 and shall provide workers' compensation insurance coverage for all those workers, unless they meet the requirements for an exemption under ORS 656.126(2). Provider shall require and ensure that each of its subcontractors complies with these requirements. If Provider is a subject employer, as defined in ORS 656.023, Provider shall also obtain employers' liability insurance coverage with limits not less than $500,000 each accident. If Provider is an employer subject to any other state's workers' compensation law, Provider shall provide workers' compensation laws including employers' liability insurance coverage with limits not less than $500,000 and shall require and ensure that each of its out-of-state subcontractors complies with these requirements.

2. **Professional Liability.**

   Covering any damages caused by an error, omission or any negligent acts related to the services to be provided under this Agreement by the Provider and Provider's subcontractors, agents, officers or employees in an amount not less than $1,000,000 per occurrence. Annual aggregate limit shall not be less than $2,000,000. If coverage is on a claims made basis, then either an extended reporting period of not less than twenty-four (24) months shall be included in the Professional Liability insurance coverage, or the Provider shall provide Tail Coverage as stated below.

3. **Commercial General Liability.**

   Commercial General Liability Insurance covering bodily injury and property damage in a form and with coverage that are satisfactory to Health Plan. This insurance shall include personal and advertising injury liability, products and completed operations, contractual liability coverage for the indemnity provided under this Agreement, and have no limitation of coverage to designated premises, project or operation. Coverage shall be written on an occurrence basis in an amount of not less than $1,000,000 per occurrence. Annual aggregate limit shall not be less than $2,000,000.

4. **Automobile Liability.**

   Automobile Liability Insurance covering Provider's business use including coverage for all owned, non-owned, or hired vehicles with a combined single limit of not less than $1,000,000 for bodily injury and property damage. This coverage may be written in

combination with the Commercial General Liability Insurance (with separate limits for Commercial General Liability and Automobile Liability). Use of personal automobile liability insurance coverage may be acceptable if evidence that the policy includes a business use endorsement is provided.

5. **Additional Insured.**

The Commercial General Liability insurance and Automobile Liability insurance required under this Agreement must include an additional insured endorsement specifying the State of Oregon, its officers, employees and agents as Additional Insureds, including additional insured status with respect to liability arising out of ongoing operations and completed operations, but only with respect to Provider's activities to be performed under this Agreement. Coverage shall be primary and non-contributory with any other insurance and self-insurance. The Additional Insured endorsement with respect to liability arising out of your ongoing operations must be on ISO Form CG 20 10 07 04 or equivalent and the Additional Insured endorsement with respect to completed operations must be on ISO form CG 20 37 04 13 or equivalent.

6. **Notice of Cancellation or Change.**

Provider shall or its insurer must provide at least 30 days' written notice to OHA before cancellation of, material change to, potential exhaustion of aggregate limits of, or non-renewal of the required insurance coverage(s).

7. **Certificate(s) and Proof of Insurance.**

Provider shall provide to Health Plan Certificate(s) of Insurance for all required insurance before delivering any Goods and performing any Services required under this Agreement. The Certificate(s) shall list the State of Oregon, its officers, employees and agents as a Certificate holder and as an endorsed Additional Insured. If excess/umbrella insurance is used to meet the minimum insurance requirement, the Certificate of Insurance must include a list of all policies that fall under the excess/umbrella insurance. As proof of insurance Health Plan has the right to request copies of insurance policies and endorsements relating to the insurance requirements in this Agreement.

8. **Tail Coverage.**

If any of the required policies is on a claims made basis and does not include an extended reporting period of at least twenty-four (24) months, 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 this Agreement, for a minimum of twenty-four (24) months following the later of (i) Provider's completion and OHA's acceptance of all Services required under this Agreement, or, (ii) Health Plan or Provider termination of agreement, or, (iii) The expiration of all warranty periods provided under this Agreement.

9. **Excess/Umbrella Insurance**.

A combination of primary and excess/umbrella insurance may be used to meet the required limits of insurance.

10. **Insurance Requirement Review.**

Provider agrees to periodic review of insurance requirements by Health Plan under this Agreement and to provide updated requirements as mutually agreed upon by Provider and Health Plan.

11. **Health Plan Acceptance.**

All insurance providers are subject to Health Plan acceptance. If requested by Health Plan, Provider shall provide complete copies of insurance policies, endorsements, self-insurance documents and related insurance documents to Health Plan's representatives responsible for verification of the insurance coverages required under this Section.