PERSONAL SERVICES AGREEMENT BETWEEN THE COUNTY OF SHASTA AND SHASTA COUNTY CHILD ABUSE PREVENTION COORDINATING COUNCIL

This agreement is entered into between the County of Shasta, a political subdivision of the State of California, through its Health and Human Services Agency ("County"), and Shasta County Child Abuse Prevention Coordinating Council, a California corporation ("Consultant"), (collectively, the "Parties" and individually a "Party"), for the purpose of providing targeted case management ("TCM") services.

RECITALS

WHEREAS, County, as the designated Local Government Agency ("LGA") for the Medi-Cal TCM Program (as Provider #17EVRGRN45) has entered into an agreement with the California Department of Health Care Services ("DHCS") to claim federal financial participation ("FFP") reimbursement for the provision of TCM services to eligible Medi-Cal beneficiaries in Shasta County;

WHEREAS, Consultant desires to provide TCM services for eligible and potentially eligible Medi-Cal beneficiaries in Shasta County;

WHEREAS, claims for FFP reimbursement for the provision of TCM services to eligible Medi-Cal beneficiaries must be made through an LGA; and

WHEREAS, Consultant desires to receive FFP reimbursement through County for the TCM services being provided.

NOW, THEREFORE, County and Consultant enter into this agreement.

Section 1. RESPONSIBILITIES OF CONSULTANT.

Pursuant to the terms and conditions of this agreement, Consultant shall:

A. Provide TCM services to eligible Medi-Cal beneficiaries in Shasta County pursuant to the terms and conditions of the agreement between the County and DHCS, attached and incorporated herein as **Attachment A**, titled "Medi-Cal Targeted Case Management Provider Participation Agreement," dated on June 20, 2017, attached and incorporated herein.

B. Provide TCM services to eligible Medi-Cal beneficiaries in Shasta County which comply with the applicable provisions of California State Plan TN No. 17-037, attached and incorporated herein as **Attachment B**, titled "Transmittal and Notice of Approval of State Plan Material," attached and incorporated herein

C. Comply with the Shasta LGA Performance Monitoring Plan, attached and incorporated herein as **Attachment C**, titled "Shasta LGA. Performance Monitoring Plan," attached and incorporated herein

D. Perform perpetual (daily) time surveys for claimed staff. The time surveys shall comply with all DHCS requirements and Consultant shall utilize DHCS approved time

survey forms. Prior to submission to County, all time surveys shall be reviewed for completeness and accuracy and corrected, when necessary, prior to submission.

E. Prepare an annual cost report in compliance with DHCS requirements.

F. Submit to County the annual cost reports prepared pursuant to subsection 1.E. of this agreement, no later than

(1) October 5, 2019 for the time period July 1, 2018 through June 30, 2019;

(2) October 5, 2020 for the time period July 1, 2019 through June 30, 2020;

(3) October 5, 2021 for the time period July 1, 2020 through June 30, 2021;

(4) October 5, 2022 for the time period July 1, 2021 through June 30, 2022; and

(5) October 5, 2023 for the time period July 1, 2022 through June 30, 2023.

This section 1.F. shall survive the termination, expiration, or cancellation of this agreement.

G. Throughout the term of this agreement, submit to County the perpetual (daily) time surveys no later than September 5th of each year for the prior July 1st through June 30th time periods. This section 1.G. shall survive the termination, expiration, or cancellation of this agreement.

H. Enter TCM encounters ("Encounter(s)") (i.e., face to face contact or significant telephone contact with or on behalf of the Medi-Cal eligible person for the purpose of rendering one or more TCM service components ["Service Components"] by a case manager) into the DHCS TCM online system, within 30 days after the end of each calendar quarter (March, June, September, December) during the term of this agreement. A Service Component includes, but is not limited to, comprehensive assessment and periodic reassessment of individual needs; development (and periodic revision) of a specific care plan; referral and related activities to help the eligible individual obtain needed services; assistance with accessing services; monitoring and follow-up activities; and periodic reviews. Required information to be entered into the TCM online system includes, but is not limited to: program type; case manager ID; location of the Encounter; date of service; date of birth; client ID; last name, if client ID has not been entered; and newborn date of birth, if applicable. For the purposes of this agreement, calendar quarters are the months of October through December, January through March, April through June, and July through September. Consultant shall notify County, within 10 working days of the beginning of each calendar quarter, as to when the Encounters have been entered into the TCM online system.

I. Provide to County (on the dates specified by County) for its review ("Chart Review"), up to 50 of Consultant's TCM files containing documentation of the provision of Service Components and Encounters undertaken pursuant to this agreement. For the purposes of this agreement, a Chart Review is a comprehensive review of TCM case documentation and billable Encounters to ensure compliance with TCM federal and state laws and regulations, and County policies and procedures. Chart Reviews shall include steps to minimize federal audit exceptions and provide continuous quality improvement. The number of TCM files and the dates of Chart Reviews shall be mutually agreed upon by County and Consultant. In the event that County and Consultant are unable to agree on a number of TCM files to be reviewed and/or the

date of a Chart Review, County shall have the right to set the number of files to be reviewed and the date of the Chart Review.

J. Maintain a TCM Encounter log ("Encounter Log") pursuant to DHCS TCM policies and procedures. The Encounter Log shall include all Encounters performed on Medi-Cal and potentially eligible Medi-Cal clients. The Encounter Log shall be maintained by Consultant and available for County and DHCS audit for the time period specified in subsection 1.K.

K. Maintain and preserve TCM records for a minimum of three years after the termination, expiration, or cancellation of County's agreement with DHCS (**Attachment A**) and final payment from DHCS to County under that agreement, or the period of time as required by applicable law or regulation, to permit DHCS or any duly authorized representative, to have access to, examine, or audit any pertinent books, documents, papers, and records related to this agreement and to allow interviews of any of Consultant's staff who might reasonably have information related to such records, whichever is later. This provision shall survive the termination, expiration, or cancellation of this agreement.

L. Utilize the websites located at http://www.maa-tcm.com and http://www.dhcs.ca.gov/provgovpart/Pages/TCM.aspx to obtain TCM forms (including time survey forms and cost reports) and program compliance information.

M. Contact the TCM Coordinator for technical assistance.

N. Attend one annual time survey training and one annual cost report training provided by County on the dates and times, and at the location(s) mutually agreed upon by County and Consultant. In the event that County and Consultant are unable to agree on dates, times, and location(s) of the annual trainings, County shall have the right to set the dates, times, and location(s) of the annual training.

O. As required by Government Code section 7550, each document or report prepared by Consultant for or under the direction of County pursuant to this agreement shall contain the numbers and dollar amount of the agreement and all subcontracts under the agreement relating to the preparation of the document or written report. If multiple documents or written reports are the subject of the agreement or subcontracts, the disclosure section may also contain a statement indicating that the total agreement amount represents compensation for multiple documents or written reports. Consultant shall label the bottom of the last page of the document or report as follows: department name, agreement number, and dollar amount. If more than one document or report is produced under this agreement, Consultant shall add: "This [document or report] is one of [number] produced under this agreement."

Section 2. **RESPONSIBILITIES OF COUNTY.**

Pursuant to the terms and conditions of this agreement, County shall:

A. Compensate Consultant as prescribed in sections 3 and 4 of this agreement and shall monitor Consultant's performance.

B. Designate a County employee as the TCM Coordinator.

C. Assist Consultant with preparation and submission of accurate and complete cost reports in accordance with subsections 1.E., and 1.F. of this agreement, provided; however, that Consultant is responsible for completion and submission of cost reports in accordance with this agreement.

D. Make reasonable efforts to provide to Consultant TCM-related information, regulation updates, and information regarding pertinent legislation.

E. Provide to Consultant TCM-related training that consists of no less than one annual time survey training and one annual cost report training

F. Generate and submit invoice forms for FFP reimbursement within 90 days of notification from Consultant that all Encounters have been entered pursuant to subsection 1.H. of this agreement.

G. Conduct Chart Reviews. In the event County finds an error during a Chart Review, County shall notify Consultant within 30 days of discovering the error and provide instructions for Consultant to perform corrective action for the error. Consultant shall take necessary corrective action within 30 days of notification to Consultant from County of the error.

Section 3. COMPENSATION.

Maximum compensation payable to Consultant for providing the services prescribed in this agreement shall not exceed the following:

A. The maximum allowable FFP reimbursement as determined by DHCS during the period July 1 through June 30 of each fiscal year throughout the term of this agreement; and

B. In no event shall maximum compensation payable by County to Consultant exceed the combined maximum allowable FFP reimbursement for County for each fiscal year, July 1 through June 30, throughout the term of this agreement.

C. Consultant's violation or breach of agreement terms may result in fiscal penalties, withholding of compensation, or termination of this agreement.

Section 4. BILLING AND PAYMENT.

A. Consultant shall be paid, within 30 days of submission of approved invoices to DHCS. Consultant shall be paid the amount County receives from DHCS for invoices submitted to DHCS, as determined by Consultant's Cost Report. County shall only be responsible to pay Consultant the amount of the FFP as directed by DHCS, and as prescribed in subsection 3.A. of this agreement.

B. Payments for a specific billing period may be delayed up to one year or more due to TCM program and billing functions.

(1) If an individual that is determined to be ineligible for Medi-Cal is subsequently found to be eligible, the TCM system will retroactively approve the Encounter(s) for payment. Consultant shall be paid as described in section 4. A. above for that individual.

(2) In the event a DHCS TCM audit results in a disallowance of reimbursement to Consultant, County shall invoice Consultant by mail for the amount of the disallowance within 10 days of receipt from DHCS of notice of the disallowance. The invoice shall be deemed received by Consultant two days after mailing. Consultant shall pay County the invoiced amount within 30 days from the date the invoice is deemed received.

C. For the purpose of effectuating compensation, this Section 4 shall survive the termination, expiration, or cancellation of this agreement.

Section 5. TERM OF AGREEMENT.

This agreement shall commence on July 1, 2018, and shall end June 30, 2023, except as to the final cost reports, time surveys, and invoices (including, but not limited to, invoices for disallowed reimbursements mailed to Consultant by County), which shall be due as provided in sections 1 and 4 of this agreement.

Section 6. TERMINATION OF AGREEMENT.

A. If Consultant materially fails to perform Consultant's responsibilities under this agreement to the satisfaction of County, or if Consultant fails to fulfill in a timely and professional manner Consultant's responsibilities under this agreement, or if Consultant violates any of the terms or provisions of this agreement, then County shall have the right to terminate this agreement for cause effective immediately upon the County giving written notice thereof to Consultant. If termination for cause is given by County to Consultant and it is later determined that Consultant was not in default or the default was excusable, then the notice of termination shall be deemed to have been given without cause pursuant to paragraph B of this section.

B. County may terminate this agreement without cause on 30 days written notice to Consultant.

C. County may terminate this agreement immediately upon oral notice should funding cease or be materially decreased during the term of this agreement.

D. County's right to terminate this agreement may be exercised by County's Health and Human Services Agency ("HHSA") Director or any HHSA Branch Director designated by the HHSA Director.

E. Should this agreement be terminated, Consultant shall promptly provide to County any and all finished and unfinished reports, data, studies, photographs, charts, and other documents prepared by Consultant pursuant to this agreement.

F. If this agreement is terminated, Consultant shall only be paid for services satisfactorily completed and provided prior to the effective date of termination.

Section 7. ENTIRE AGREEMENT; AMENDMENTS; HEADINGS; EXHIBITS/APPENDICES.

A. This agreement supersedes all previous agreements relating to the subject of this agreement and constitutes the entire understanding of the Parties hereto. Consultant shall be entitled to no other benefits other than those specified herein. Consultant

specifically acknowledges that in entering into and executing this agreement, Consultant relies solely upon the provisions contained in this agreement and no others.

B. No changes, amendments, or alterations to this agreement shall be effective unless in writing and signed by both Parties. However, minor amendments, including retroactive, that do not result in a substantial or functional change to the original intent of this agreement and do not cause an increase to the maximum amount payable under this agreement may be agreed to in writing between Consultant and the HHSA Director or any HHSA Branch Director designated by the HHSA Director, provided that the amendment is in substantially the same format as the County's standard format amendment contained in the Shasta County Contracts Manual (Administrative Policy 6-101).

C. The headings that appear in this agreement are for reference purposes only and shall not affect the meaning or construction of this agreement.

D. If any ambiguity, inconsistency, or conflict exists or arises between the provisions of this agreement and the provisions of any of this agreement's exhibits or appendices, the provisions of this agreement shall govern.

Section 8. NONASSIGNMENT OF AGREEMENT; NON-WAIVER.

Inasmuch as this agreement is intended to secure the specialized services of Consultant, Consultant may not assign, transfer, delegate, or sublet any interest herein without the prior written consent of County. The waiver by County of any breach of any requirement of this agreement shall not be deemed to be a waiver of any other breach.

Section 9. EMPLOYMENT STATUS OF CONSULTANT.

Consultant shall, during the entire term of this agreement, be construed to be an independent contractor, and nothing in this agreement is intended nor shall be construed to create an employer-employee relationship, a joint venture relationship, or to allow County to exercise discretion or control over the professional manner in which Consultant performs the work or services that are the subject matter of this agreement; provided, however, that the work or services to be provided by Consultant shall be provided in a manner consistent with the professional standards applicable to such work or services. The sole interest of County is to insure that the work or services shall be rendered and performed in a competent, efficient, and satisfactory manner. Consultant shall be fully responsible for payment of all taxes due to the State of California or the federal government that would be withheld from compensation if Consultant were a County employee. County shall not be liable for deductions for any amount for any purpose from Consultant's compensation. Consultant shall not be eligible for coverage under County's workers' compensation insurance plan nor shall Consultant be eligible for any other County benefit. Consultant must issue W-2 and 941 Forms for income and employment tax purposes, for all of Consultant's assigned personnel under the terms and conditions of this agreement.

Section 10. INDEMNIFICATION.

To the fullest extent permitted by law, Consultant shall indemnify and hold harmless County, its elected officials, officers, employees, agents, and volunteers against all claims,

suits, actions, costs, expenses (including, but not limited to, reasonable attorney's fees of County Counsel and counsel retained by County, expert fees, litigation costs, and investigation costs), damages, judgments, or decrees arising from the work or the provision of services undertaken pursuant to this agreement by Consultant, or by any of Consultant's subcontractors, any person employed under Consultant, or under any subcontractor, or in any capacity, except when the injury or loss is caused by the sole negligence or intentional wrongdoing of County. Consultant shall also, at Consultant's own expense, defend the County, its elected officials, officers, employees, agents, and volunteers, against any claim, suit, action, or proceeding brought against County, its elected officials, officers, employees, agents, and volunteers, arising from the work or the provision of services undertaken pursuant to this agreement by Consultant, or any of Consultant's subcontractors, any person employed under Consultant, or under any subcontractor, or in any capacity. Consultant shall also defend and indemnify County for any adverse determination made by the Internal Revenue Service or the State Franchise Tax Board and/or any other taxing or regulatory agency and shall defend, indemnify, and hold harmless County with respect to Consultant's "independent contractor" status that would establish a liability on County for failure to make social security deductions or contributions or income tax withholding payments, or any other legally mandated payment. The provisions of this paragraph are intended to be interpreted as broadly as permitted by applicable law. This provision shall survive the termination, expiration, or cancellation of this agreement.

Section 11. INSURANCE COVERAGE.

A. Without limiting Consultant's duties of defense and indemnification, Consultant and any subcontractor shall obtain, from an insurance carrier authorized to transact business in the State of California, and maintain continuously during the term of this agreement Commercial General Liability Insurance, including coverage for owned and non-owned automobiles, and other coverage necessary to protect County and the public with limits of liability of not less than $1 million per occurrence; such insurance shall be primary as to any other insurance maintained by County.

B. Consultant shall obtain and maintain continuously a policy of Errors and Omissions coverage with limits of liability of not less than $1 million per occurrence.

C. Consultant and any subcontractor shall obtain and maintain continuously required Workers' Compensation and Employer's Liability Insurance to cover Consultant, subcontractor, Consultant's partner(s), subcontractor's partner(s), Consultant's employees, and subcontractor'(s') employees with an insurance carrier authorized to transact business in the State of California covering the full liability for compensation for injury to those employed by Consultant or subcontractor. Each such policy shall be endorsed to state that the Workers' Compensation carrier waives its right of subrogation against *County, its elected officials, officers, employees, agents, and volunteers* which might arise in connection with this agreement. Consultant hereby certifies that Consultant is aware of the provisions of section 3700 of the Labor Code, which requires every employer to insure against liability for workers' compensation or to undertake self-insurance in accordance with the provisions of the Labor Code, and Consultant shall comply with such provisions before commencing the performance of the work or the provision of services pursuant to this agreement.

D. Consultant shall require subcontractors to furnish satisfactory proof to County that liability and workers' compensation and other required types of insurance have been obtained and are maintained similar to that required of Consultant pursuant to this agreement.

E. With regard to all insurance coverage required by this agreement:

(1) Any deductible or self-insured retention exceeding $25,000 for Consultant or subcontractor shall be disclosed to and be subject to approval by the County Risk Manager prior to the effective date of this agreement.

(2) If any insurance coverage required hereunder is provided on a "claims made" rather than "occurrence" form, Consultant or subcontractor shall maintain such insurance coverage with an effective date earlier or equal to the effective date of this agreement and continue coverage for a period of three years after the expiration of this agreement and any extensions thereof. In lieu of maintaining post-agreement expiration coverage as specified above, Consultant or subcontractor may satisfy this provision by purchasing tail coverage for the claims-made policy. Such tail coverage shall, at a minimum, provide the insurance coverage required hereunder for claims received and reported three years after the expiration date of this agreement.

(3) All insurance (except workers' compensation and professional liability) shall include an endorsement or an amendment to the policy of insurance which names *County, its elected officials, officers, employees, agents, and volunteers as additional insureds.* In the event that coverage is reduced or canceled, a notice of said reduction or cancellation shall be provided to County within 24 hours. . Any available insurance proceeds in excess of the specified minimum limits and coverage pursuant to the terms of this agreement shall be applicable to the Additional Insured. The additional insureds coverage shall be equal to Insurance Service Office endorsement CG 20 10 for on-going operations, and CG 20 37 for completed operations.

(4) Each insurance policy (except for workers' compensation and professional liability policies), or an endorsement thereto, shall contain a "separation of insureds" clause which shall read:

"Separation of Insureds.

Except with respect to the Limits of Insurance, and any rights or duties specifically assigned in this Coverage Part to the first Named Insured, this insurance applies:

a. As if each Named Insured were the only Named Insured; and

b. Separately to each suit insured against whom a claim is made or suit is brought."

(5) Consultant shall provide County with an endorsement or amendment to Consultant's policy of insurance as evidence of insurance protection before the effective date of this agreement.

(6) The insurance coverage required herein shall be in effect at all times during the term of this agreement. In the event any insurance coverage expires at any time

during the term of this agreement, Consultant shall provide County, at least 20 days prior to said expiration date, a new endorsement or policy amendment evidencing insurance coverage as provided for herein for not less than the remainder of the term of this agreement or for a period of not less than one year. In the event Consultant fails to keep in effect at all times insurance coverage as herein provided and a renewal endorsement or policy amendment is not provided within 10 days of the expiration of the endorsement or policy amendment in effect at inception of this agreement, County may, in addition to any other remedies it may have, terminate this agreement upon the occurrence of such event.

(7) If the endorsement or amendment does not reflect the limits of liability provided by the policy of insurance, Consultant shall provide County a certificate of insurance reflecting those limits.

(8) Any of Consultant's Excess Insurance shall contain a provision that such coverage shall also apply on a primary and non-contributory basis for the benefit of County.

Section 12. NOTICE OF CLAIM; APPLICABLE LAW; VENUE.

A. If any claim for damages is filed with Consultant or if any lawsuit is instituted concerning Consultant's performance under this agreement and that in any way, directly or indirectly, contingently or otherwise, affects or might reasonably affect County, Consultant shall give prompt and timely notice thereof to County. Notice shall be prompt and timely if given within 30 days following the date of receipt of a claim or 10 days following the date of service of process of a lawsuit. This provision shall survive the termination, expiration, or cancellation of this agreement.

B. Any dispute between the Parties, and the interpretation of this agreement, shall be governed by the laws of the State of California. Any litigation shall be venued in Shasta County.

Section 13. COMPLIANCE WITH LAWS; NON-DISCRIMINATION.

A. Consultant shall observe and comply with all applicable present and future federal laws, state laws, local laws, codes, rules, regulations, and/or orders that relate to the work or services to be provided pursuant to this agreement.

B. Consultant shall not discriminate in employment practices or in the delivery of services on the basis of race, color, creed, religion, national origin, sex, age, marital status, sexual orientation, medical condition (including cancer, HIV, and AIDS) physical or mental disability, use of family care leave under either the Family & Medical Leave Act or the California Family Rights Act, or on the basis of any other status or conduct protected by law.

C. Consultant represents that Consultant is in compliance with and agrees that Consultant shall continue to comply with the Americans with Disabilities Act of 1990 (42 U.S.C. sections 12101, *et seq.*), the Fair Employment and Housing Act (Government Code sections 12900, *et seq.*), and regulations and guidelines issued pursuant thereto.

D. In addition to any other provisions of this agreement, Consultant shall be solely responsible for any and all damages caused, and/or penalties levied, as the result of Consultant noncompliance with the provisions of this section.

Section 14. ACCESS TO RECORDS; RECORDS RETENTION.

A. County, federal, and state officials shall have access to any books, documents, papers, and records of Consultant that are directly pertinent to the subject matter of this agreement for the purpose of auditing or examining the activities of Consultant or County. Except where longer retention is required by federal or state law, Consultant shall maintain all records for five years after County makes final payment hereunder. This provision shall survive the termination, expiration, or cancellation of this agreement.

B. Consultant shall maintain appropriate records to insure a proper accounting of all funds and expenditures pertaining to the work performed or the services provided pursuant to this agreement. Consultant shall maintain records providing information that account for all funds and expenses related to the provision of services provided pursuant to this agreement. Access to these records shall be provided to County during working days, 8:00 a.m. to 5:00 p.m. and at other times upon reasonable notice by County, and upon request of state and federal agencies charged with the administration of programs related to the work or services to be provided pursuant to this agreement.

C. Consultant agrees to accept responsibility for receiving, replying to, and/or complying with any audit exception by appropriate federal, state, or County audit directly related to the provisions of this agreement. Consultant agrees to repay County the full amount of payment received for duplicate billings, erroneous billings, audit exceptions, or false or deceptive claims. Consultant agrees that County may withhold any money due and recover through any appropriate method any money erroneously paid under this agreement if evidence exists of less than full compliance with this agreement including, but not limited to, exercising a right of set-off against any compensation payable to Consultant.

Section 15. COMPLIANCE WITH CHILD, FAMILY, AND SPOUSAL SUPPORT REPORTING OBLIGATIONS.

Consultant's failure to comply with state and federal child, family, and spousal support reporting requirements regarding Consultant's employees or failure to implement lawfully served wage and earnings assignment orders or notices of assignment relating to child, family, and spousal support obligations shall constitute a default under this agreement. Consultant's failure to cure such default within 90 days of notice by County shall be grounds for termination of this agreement.

Section 16. LICENSES AND PERMITS.

Consultant, and Consultant's officers, employees, and agents performing the work or services required by this agreement, shall possess and maintain all necessary licenses, permits, certificates, and credentials required by the laws of the United States, the State of California, the County of Shasta, and all other appropriate governmental agencies,

including any certification and credentials required by County. Failure to maintain the licenses, permits, certificates, and credentials shall be deemed a breach of this agreement and constitutes grounds for the termination of this agreement by County.

Section 17. PERFORMANCE STANDARDS.

Consultant shall perform the work or services required by this agreement in accordance with the industry and/or professional standards applicable to Consultant's work or services.

Section 18. CONFLICTS OF INTEREST.

Consultant and Consultant's officers and employees shall not have a financial interest, or acquire any financial interest, direct or indirect, in any business, property, or source of income that could be financially affected by or otherwise conflict in any manner or degree with the performance of the work or services required under this agreement.

Section 19. NOTICES.

A. Except as provided in section 6.C. of this agreement (oral notice of termination due to insufficient funding), any notices required or permitted pursuant to the terms and provisions of this agreement shall be given to the appropriate Party at the address specified below or at such other address as the Party shall specify in writing. Such notice shall be deemed given: (1) upon personal delivery; or (2) if sent by first class mail, postage prepaid, two days after the date of mailing.

If to County:
Branch Director
HHSA Business and Support Services
Attn: Contracts Unit
P.O. Box 496005
Redding, CA 96049-6005
Phone: 530-245-6860
Fax: 530-225-5555

Copy to:
TCM Coordinator
HHSA Business & Support Services
P.O. Box 496005
Redding, CA 96001-6005

If to Consultant:
Executive Director
Child Abuse Prevention Coordinating Council
2280 Benton Drive, Building C, Suite A
Redding, CA 96003
Phone: 530-241-5816
Fax: 530-241-4192

Copy to:
Project Director
Child Abuse Prevention Coordinating Council
2280 Benton Drive, Building C, Suite A

B. Any oral notice authorized by this agreement shall be given to the persons specified in Section 19.A. and shall be deemed to be effective immediately.

C. Unless otherwise stated in this agreement, any written or oral notices on behalf of the County as provided for in this agreement may be executed and/or exercised by the County Executive Officer.

Section 20. AGREEMENT PREPARATION.

It is agreed and understood by the Parties that this agreement has been arrived at through negotiation and that neither Party is to be deemed the Party which created any uncertainty in this agreement within the meaning of section 1654 of the Civil Code.

Section 21. COMPLIANCE WITH POLITICAL REFORM ACT.

Consultant shall comply with the California Political Reform Act (Government Code, sections 81000, *et seq.*), with all regulations adopted by the Fair Political Practices Commission pursuant thereto, and with the County's Conflict of Interest Code, with regard to any obligation on the part of Consultant to disclose financial interests and to recuse from influencing any County decision which may affect Consultant's financial interests. If required by the County's Conflict of Interest Code, Consultant shall comply with the ethics training requirements of Government Code sections 53234, *et seq.*

Section 22. PROPERTY TAXES.

Consultant represents and warrants that Consultant, on the date of execution of this agreement, (1) has paid all property taxes for which Consultant is obligated to pay, or (2) is current in payments due under any approved property tax payment arrangement. Consultant shall make timely payment of all property taxes at all times during the term of this agreement.

Section 23. SEVERABILITY.

If any portion of this agreement or application thereof to any person or circumstance is declared invalid by a court of competent jurisdiction or if it is found in contravention of any federal or state statute or regulation or County ordinance, the remaining provisions of this agreement, or the application thereof, shall not be invalidated thereby and shall remain in full force and effect to the extent that the provisions of this agreement are severable.

Section 24. COUNTY'S RIGHT OF SETOFF.

To the fullest extent permitted by law, County shall have the right but not the obligation, to setoff, in whole or in part, against-any compensation owed to Consultant or any of its subsidiaries under any contract with the County, any amount of any Federal or State audit liability owed by or claimed or asserted against the County or any amounts owed to County by Consultant or its subsidiaries.

Section 25. CONFIDENTIALITY.

During the term of this agreement, both Parties may have access to information that is confidential or proprietary in nature. Both Parties agree to preserve the confidentiality of and to not disclose any such information to any third party without the express written consent of the other Party or as required by law. This provision shall survive the termination, expiration, or cancellation of this agreement.

Section 26. SCOPE AND OWNERSHIP OF WORK.

All research data, reports, and every other work product of any kind or character arising from or relating to this agreement shall become the property of the County and be delivered to the County upon completion of its authorized use pursuant to this agreement. County may use such work products for any purpose whatsoever. All works produced under this agreement shall be deemed works produced by a Consultant for hire, and all copyright with respect thereto shall vest in the County without payment of royalty or any other additional compensation. Notwithstanding anything to the contrary contained in this agreement, Consultant shall retain all of Consultant's rights in Consultant's own proprietary information, including, without limitation, Consultant's methodologies and methods of analysis, ideas, concepts, expressions, know how, methods, techniques, skills, knowledge, and experience possessed by Consultant prior to, or acquired by Consultant during the performance of this agreement and Consultant shall not be restricted in any way with respect thereto.

Section 27. USE OF COUNTY PROPERTY.

Consultant shall not use County premises, property (including equipment, instruments, and supplies), or personnel for any purpose other than in the performance of Consultant's obligations under this agreement.

Section 28. APPLICATION OF OTHER AGREEMENTS.

Consultant and Consultant's officers, agents, employees, and volunteers, and any of Consultant's/consultant's subcontractors shall comply with all terms and provisions imposed upon any subcontractor of County by the Medi-Cal Targeted Case Management Provider Participation Agreement between the County of Shasta and California Department of Health Care Services, PPA#45-17EVRGRN, attached to this agreement as **Attachment A** and incorporated by this reference.

[SIGNATURE PAGE FOLLOWS]

IN WITNESS WHEREOF, County and Consultant have executed this agreement on the dates set forth below. By their signatures below, each signatory represents that he/she has the authority to execute this agreement and to bind the Party on whose behalf his/her execution is made.

COUNTY OF SHASTA

Date:_____

_____
LES BAUGH, CHAIRMAN
Board of Supervisors
County of Shasta
State of California

ATTEST:

LAWRENCE G. LEES
Clerk of the Board of Supervisors

By: _____
Deputy

Approved as to form:
RUBIN E. CRUSE, JR
County Counsel

By: _____ 7/13/18
Alan B. Cox
Deputy County Counsel

RISK MANAGEMENT APPROVAL

By: _____ 7/19/2018
James Johnson
Risk Management Analyst

INFORMATION TECHNOLOGY APPROVAL

By: _____ 7-23-2018
Tom Schreiber
Chief Information Officer

Date: 7/24/18

CONSULTANT

_____
Linda Ram, Executive Director
Shasta County Child Abuse Prevention Coordinating Council

Tax I.D.#: On File

ATTACHMENT A

MEDI-CAL TARGETED CASE MANAGEMENT PROVIDER PARTICIPATION AGREEMENT

Name of Provider: County of Shasta PPA # 45-17EVRGRN

The parties agree that this Provider Participation Agreement replaces the prior Provider Participation Agreement # 45-1318A, dated September 11, 2015 by replacing 45-1318A in its entirety.

1. PARTIES AND AUTHORITY

This Provider Participation Agreement (Agreement) sets out the responsibilities of the California qualified local governmental agency (Provider), and California Department of Health Care Services (DHCS), for the provision of Targeted Case Management (TCM) services to eligible Medi-Cal beneficiaries, pursuant to Welfare and Institutions (W & I) Code Section 14132.44. This Agreement constitutes the entire TCM agreement between the Provider and DHCS and is subordinate to the Medi-Cal Provider Agreement (DHCS Form 6208) entered into by the Provider in conjunction with the Provider's enrollment in the Medi-Cal Program. Provider shall be an entity located and operating in the State of California.

2. TERM AND TERMINATION OF THE AGREEMENT

This Agreement will be effective on July 1, 2017 and shall continue in full force and effect until terminated by either party.

Termination without Cause: Either party may terminate this Agreement by providing the other party with 30 days advance written notice of intent to terminate. Termination shall result in Provider's immediate disenrollment from the TCM program on the termination date and exclusion (without formal hearing under the Administrative Procedure Act) from further participation in the TCM program unless and until such time as Provider is re-enrolled by DHCS in the TCM program.

Termination for Cause: This Agreement shall be automatically terminated or suspended if the Provider's DHCS Form 6208 is terminated or Provider is suspended under the terms of the DHCS Form 6208, respectively. This Agreement's automatic termination or suspension shall be effective the same date as the Provider's DHCS Form 6208 termination or Provider's suspension. Termination will result in Provider's immediate disenrollment and exclusion (without formal hearing under the Administrative Procedure Act) from further providing service under the TCM program.

3. CONTACT PERSONS

A. The contact persons during the term of this Agreement are:

Department of Health Care Services	Provider
Shelly Taunk, Chief County-Based Claiming and Inmate Services Section Telephone: (916) 322-2551 Fax: (916) 324-0738 Email: Shelly.Taunk@dhcs.ca.gov	Name: Robin Harris Telephone: (530) 225-5918 Fax: (530) 225-5555 Email: rmharris!co.shasta.ca.us

B. Direct all inquiries to:

Department of Health Care Services	Provider
County-Based Claiming and Inmate Services Section Targeted Case Management Unit Attention: TCM Unit Chief Suite 71.3024, MS 4603 P.O. Box 997436 Sacramento, CA, 95899-7436 Phone: (916) 552-9056 Fax: (916) 324-0738 Email: DHCS-TCM@dhcs.ca.gov	County of Shasta Health & Human Services Agency Attn: MAA/TCM Coordinator P.O. Box 496005 Redding, CA 96049-6005 Phone: (530) 225-5918 Fax: (530) 225-5555 Email: rmharris@co.shasta.ca.us

C. Either party may make changes to the information above by giving written notice to the other party. Said changes shall not require an amendment to this agreement.

4. PROVIDER RESPONSIBILITIES

By entering into this Agreement, the Provider agrees to:

A. Ensure all applicable State and federal requirements are met with regard to Expense Allowability / Fiscal Documentation:

1) TCM Summary Invoices, received from a Provider and accepted and/or submitted for payment by DHCS, shall not be deemed evidence of allowable agreement costs.

2) Supporting documentation of all amounts invoiced shall be maintained for review and audit, and supplied to DHCS upon request, pursuant to this Agreement to permit a determination of expense allowability.

a) If the allowability or appropriateness of an expense cannot be determined by DHCS because invoice detail, fiscal records, or backup documentation is nonexistent or inadequate, according to generally accepted accounting principles or practices, all questioned costs may be disallowed and payment may be withheld or recouped by DHCS. Upon receipt of adequate documentation supporting a disallowed or questioned expense, reimbursement may resume for the amount substantiated and deemed allowable.

B. TCM providers and their subcontractors are considered contractors solely for the purposes of U.S. Office of Management and Budget Uniform Guidance (Title 2 of the Code of Federal Regulations, Part 200, and, specifically, 2 CFR 200.330). Consequently, as a contractor, as distinguished from subrecipient, a Dun and Bradstreet Universal Numbering System (DUNS) number is not required.

C. Designate MEDS Access Liaisons responsible for working directly with DHCS in requesting MEDS access for county/city TCM staff. All MEDS Access Liaisons shall sign a MEDS Oath of Confidentiality provided by DHCS. This Liaison is responsible for maintaining an active list of Provider users with MEDS access and collecting a signed Oath of Confidentiality from each user. The Liaison is responsible for ensuring users are informed they cannot share user accounts, that MEDS is to be used for only authorized purposes, and that all activity is logged. DHCS will only accept account requests from an authorized MEDS Access Liaison. The Liaison may be changed by written notice to DHCS. The MEDS Authorization Liaison should be an employee at an appropriate level in the organization, with sufficient responsibility to carry out the duties of this position. DHCS will only accept account requests from an authorized MEDS Access Liaison. DHCS will determine the number of county/city TCM staff allowed to access MEDS. DHCS may deny access to MEDS at its discretion.

1) The MEDS Access Liaison will provide, assign, delete, and track user log-in identification codes generated through DHCS to authorized TCM staff members upon request. The processing of log-in identification codes will be submitted electronically to DHCS to activate (i.e., add, delete, or reset) MEDS access upon receipt.

2) The Liaison is responsible for ensuring processes are in place which result in prompt MEDS account deletion requests when Provider users leave employment or no longer require access due to change in job duties. The Liaison must perform a monthly reconciliation to identify account termination process violations and ensure corrective actions are implemented.

D. Adhere to the following documents and any subsequent updates that are not attached, but are incorporated herein and made a part hereof by this reference. The Provider is required to fully comply with the directives in each document incorporated by reference herein and each update thereto. These documents may

be updated periodically by DHCS, as required by program directives or changes in law or policy. Unless otherwise indicated, DHCS shall provide the Provider with copies of said documents at or before the agreement is presented to the Provider for review, acceptance, and signature and will require acknowledgement of receipt. Periodic updates to the below listed documents that are not electronically accessible via the Internet, an Extranet link or other mechanism will be presented to the Provider under separate cover and acknowledgement of receipt will be required. DHCS will maintain on file, all documents referenced herein and any subsequent updates.

1) Information Exchange Agreement (IEA) between the Social Security Administration and the California Department of Health Care Services (State Agency).

   a) The specific sections of the IEA and attachments with substantive privacy and security requirements, which are to be complied with by the Provider are in the following:

      (1) Section E: Security Procedures
      (2) Section F: Contractor/Agent Responsibilities
      (3) Section G: Safeguarding and Reporting Responsibilities for PII.
      (4) Attachment 1: Computer Matching and Privacy Protection Act Agreement between the SSA and the California Health and Human Services Agency (CHHS)
      (5) Attachment 2: Authorized Data Exchange System(s).
      (6) Attachment 3: Electronic Information Exchange Security Requirements and Procedures.
      (7) Attachment 4: Worksheet for Reporting Loss or Potential Loss of Personally Identifiable Information

E. By November 1 of each year:

1) Submit an annual electronic TCM Cost Report for the service period of July 1 through June 30 to dhsaitcm@dhcs.ca.gov

   a) Electronic mail (e-mail) submission shall include the following completed documents:

      (1) Completed Cost Report Template signed and scanned (PDF)
      (2) Completed Cost Report Template (Excel)
      (3) LGA certification page signed and scanned (PDF)
      (4) Non-LGA LPE Certification and LGA Attestation Statements for TCM Cost Report signed and scanned (PDF), if applicable.

   b) Each e-mail submission shall follow the example below when naming the electronic files for the e-mail submission of the Cost Report:

Example:

2013 Santa Cruz CR.xls (Fiscal Year [FY] 2013-14 Santa Cruz Cost Report, Excel version)
2013 Santa Cruz CR.PDF (FY 2013-14 Santa Cruz Cost Report, signed and scanned PDF version)

c) Each e-mail submission shall follow the example below when naming the e-mail for the submission of the Cost Report:

Example:

Name of LGA, LGA Code, Fiscal Year End Date (FYE), Part xx.
Santa Cruz County 44 FYE 063014 Part 1 of 3

F. Accept payments as reimbursement in full as received for TCM services pursuant to this Agreement. Payments are subject to be reviewed and audited by DHCS and Centers for Medicare and Medicaid (CMS).

G. Submit TCM Summary Invoices in accordance with 42 CFR 433.51, Title 22 CCR Sections 51185, 51271, 51272, 51351, 51351.1, 51365, 51535.7, and 51492, and ensure TCM Summary Invoices are postmarked within 12 months from the date of service.

H. Execute a Memorandum of Understanding (MOU) with Medi-Cal Managed Care Health Plan(s) serving beneficiaries in the same county as the Provider when the Provider is in a Geographic Managed Care, Two-Plan Managed Care, Regional Model, Imperial Model, San Benito Model, or County Organized Health System county in accordance with State issued policy directives, including Policy and Procedure Letters (PPLs) and federal directives, all as periodically amended. The MOU will serve to define the respective responsibilities between LGA's TCM program and Medi-Cal Managed Care Health Plans and must include coordination protocols to ensure non-duplication of services provided to beneficiaries in common.

5. DHCS RESPONSIBILITIES

By entering into this Agreement, DHCS agrees to:

A. Establish an all-inclusive interim rate for the Provider to claim for TCM services.

B. Provide the TCM program with inquiry-only MEDS accounts. These MEDS accounts will be used by Providers to perform various activities, including but not limited to, providing specialized case management services to Medi-Cal eligible

individuals in a defined target population to gain access to needed medical, social, educational, and other services.

C. Perform settlement reconciliation to reflect the actual costs the Provider incurred in providing TCM services to Medi-Cal beneficiaries.

D. Review and process TCM Summary Invoices within 24 months from the date of service. Upon review, processing, and approval of valid TCM encounters, TCM Summary Invoices shall then be scheduled for payment.

E. Provide training and technical assistance to enable the Provider to identify costs related to proper invoicing documentation and billing procedures. The State will provide oversight to ensure compliance with the W&I Code Section 14132.44 and all other governing federal and State laws and regulations.

6. FISCAL PROVISIONS

Reimbursement under this Agreement shall be made in the following manner:

A. Upon the Provider's compliance with all provisions pursuant to W&I Code Section 14132.44, Title 22 CCR Division 3 (commencing with Section 50000), and this Agreement, and upon the submission of a TCM Summary Invoice, based on valid and substantiated information, DHCS agrees to process the TCM Summary Invoice for reimbursement.

B. Transfer of funds is contingent upon the availability of federal financial participation (FFP).

C. The Provider shall verify the certified public expenditure (CPE) from the Provider's General Fund, or from any other funds allowed under federal law and regulation, for Title XIX funds claimed for TCM services performed pursuant to W&I Code Section 14132.44. DHCS shall deny payment of any TCM Summary Invoice submitted under this Agreement, if it determines that the certification is not adequately supported for purposes of FFP. Expenditures certified for TCM costs shall not duplicate, in whole or in part, claims made for the costs of direct patient services.

D. Failure to timely submit cost reports, or other documents to verify CPE, by the Provider within the statutory, regulatory, or contractual deadline shall entitle DHCS to declare any funds forwarded to the Provider for the cost report period as an overpayment and recoup the funds.

E. It is mutually agreed that if the Budget Act for the current year and/or any subsequent years covered under this Agreement does not appropriate sufficient funds for the program, this Agreement shall be of no further force and effect. In this event DHCS shall have no liability to pay any funds whatsoever to the Provider

or to furnish any other considerations under this Agreement and the Provider shall not be obligated to further provide services under the TCM program.

F. If funding for any FY is reduced or deleted by the Budget Act for purposes of the TCM Program, DHCS shall have the option to either cancel this Agreement, with no liability occurring to DHCS, or offer an agreement amendment to the Provider to reflect the reduced amount.

7. LIMITATION OF STATE LIABILITY

A. Notwithstanding any other provision of this Agreement, DHCS shall be held harmless from any federal audit disallowance and interest resulting from payments made by the federal Medicaid program as reimbursement for claims providing TCM services pursuant to W&I Code Section 14132.44, for the disallowed claim or claims, less the amounts already remitted to DHCS pursuant to W&I Code Section 14132.44(m).

B. To the extent that a federal audit disallowance and interest results from a claim or claims for which the Provider has received reimbursement for TCM services, DHCS shall recoup from the Provider, upon written notice, amounts equal to the amount of the disallowance and interest in that FY for the disallowed claim or claims. All subsequent TCM Summary Invoices submitted to DHCS applicable to any previously disallowed claim or claims, may be held in abeyance, with no payment made, until the federal disallowance issue is resolved, less the amounts already remitted to DHCS pursuant to W&I Code Section 14132.44(m).

C. Notwithstanding sections 2, 6E, and 6F, to the extent that a federal audit disallowance and interest results from a claim or claims for which the Provider has received reimbursement for TCM services provided by a nongovernmental entity under contract with, and on behalf of the Provider, DHCS shall be held harmless by the Provider for 100 percent of the amount of any such federal audit disallowance and interest, for the disallowed claim or claims, less the amounts already remitted to DHCS pursuant to W&I Code Section 14132.44(m).

D. Notwithstanding sections 2, 6E, and 6F, the Provider agrees that when it is established upon audit or reconciliation that an overpayment, or other recovery determination, has been made, DHCS and Provider shall follow current laws, regulations, and State issued policy directives, including PPLs for the proper treatment of identified overpayment.

E. DHCS reserves the right to select the method to be employed for the recovery of an overpayment, or other recovery determination.

F. Overpayments may be assessed interest charges, and may be assessed penalties, in accordance with W&I Code Sections 14171(h) and 14171.5, respectively.

8. AMENDMENT

Should either party, during the term of this Agreement, desire a change or amendment to the Articles of this Agreement, such changes or amendments shall be proposed in writing to the other party, who will respond in writing as to whether the proposed changes/amendments are accepted or rejected. If accepted and after negotiations are concluded, the agreed upon changes shall be made through a process that is mutually agreeable to both DHCS and the Provider. No amendment will be considered binding on either party until it is approved by DHCS.

9. GENERAL PROVISIONS

A. This document, including any attachments or exhibits, constitutes the entire Agreement between the parties pertaining to the TCM program. Notwithstanding the DHCS Form 6208, any condition, provision, agreement or understanding not stated in this Agreement shall not affect any rights, duties, or privileges in connection with the terms of this Agreement. If there is a conflict between this Agreement and the DHCS Form 6208, then the DHCS Form 6208 shall control. Form 6208 hereby is incorporated by reference and is made part of this Agreement.

B. The term "days" as used in this Agreement shall mean calendar days unless specified otherwise.

C. The provisions and obligations of this Agreement cannot be waived or altered except through an amendment made in accordance with Section 8.

D. None of the provisions of this Agreement are or shall be construed as for the benefit of, or enforceable by, any person not a party to this Agreement.

###

Name of Provider: County of Shasta
PPA #: 45-17EVRGRN

TCM AGREEMENT EXECUTION

The undersigned agent agrees to the terms above, and enters into this Agreement on behalf of County of Shasta (Local Governmental Agency). This Agreement does not go into force until signed by California Department of Health Care Services.

Provider Authorized Person's Signature

DAVID A. KEHOE
Print Name

Chairman, Shasta County Board of Supervisors
Title

P.O. Box 496005, Redding, CA 96049-6005
Address

JUN 20 2017
Date

California Department of Health Care Services
Authorized Contact Person's Signature

John Mendoza
Print Name

Chief, Safety Net Financing Division
Title

Department of Health Care Services
Name of Department

1501 Capitol Avenue, MS 4603, Sacramento, CA 95899-7413
Address

7/3/17
Date

ATTEST:
LAWRENCE G. LEES
Clerk of the Board of Supervisors

By: _____
Deputy

Approved as to form:
RUBIN E. CRUSE, JR
County Counsel

By: _____ 6/7/17
Alan B. Cox
Deputy County Counsel

RISK MANAGEMENT APPROVAL

By: _____ 06/08/17
James Johnson
Risk Management Analyst

INFORMATION TECHNOLOGY APPROVAL

By: _____ 6-8-2017
Tom Schreiber
Chief Information Officer

Exhibit A
HIPAA Business Associate Addendum

I. Recitals

A. This Contract (Agreement) has been determined to constitute a business associate relationship under the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ('the HITECH Act"), 42 U.S.C. section 17921 et seq., and their implementing privacy and security regulations at 45 CFR Parts 160 and 164 ("the HIPAA regulations").

B. The Department of Health Care Services ("DHCS") wishes to disclose to Business Associate certain information pursuant to the terms of this Agreement, some of which may constitute Protected Health Information ("PHI"), including protected health information in electronic media ("ePHI"), under federal law, and personal information ("PI") under state law.

C. As set forth in this Agreement, Contractor, here and after, is the Business Associate of DHCS acting on DHCS' behalf and provides services, arranges, performs or assists in the performance of functions or activities on behalf of DHCS and creates, receives, maintains, transmits, uses or discloses PHI and PI. DHCS and Business Associate are each a party to this Agreement and are collectively referred to as the "parties."

D. The purpose of this Addendum is to protect the privacy and security of the PHI and PI that may be created, received, maintained, transmitted, used or disclosed pursuant to this Agreement, and to comply with certain standards and requirements of HIPAA, the HITECH Act and the HIPAA regulations, including, but not limited to, the requirement that DHCS must enter into a contract containing specific requirements with Contractor prior to the disclosure of PHI to Contractor, as set forth in 45 CFR Parts 160 and 164 and the HITECH Act, and the Final Omnibus Rule as well as the Alcohol and Drug Abuse patient records confidentiality law 42 CFR Part 2, and any other applicable state or federal law or regulation. 42 CFR section 2.1(b)(2)(B) allows for the disclosure of such records to qualified personnel for the purpose of conducting management or financial audits, or program evaluation. 42 CFR Section 2.53(d) provides that patient identifying information disclosed under this section may be disclosed only back to the program from which it was obtained and used only to carry out an audit or evaluation purpose or to investigate or prosecute criminal or other activities, as authorized by an appropriate court order.

E. The terms used in this Addendum, but not otherwise defined, shall have the same meanings as those terms have in the HIPAA regulations. Any reference to statutory or regulatory language shall be to such language as in effect or as amended.

II. Definitions

A. Breach shall have the meaning given to such term under HIPAA, the HITECH Act, the HIPAA regulations, and the Final Omnibus Rule.

B. Business Associate shall have the meaning given to such term under HIPAA, the HITECH Act, the HIPAA regulations, and the final Omnibus Rule.

C. Covered Entity shall have the meaning given to such term under HIPAA, the HITECH Act, the HIPAA regulations, and Final Omnibus Rule.

D. Electronic Health Record shall have the meaning given to such term in the HITECH Act, including, but not limited to, 42 U.S.C Section 17921 and implementing regulations.

Exhibit A
HIPAA Business Associate Addendum

E. Electronic Protected Health Information (ePHI) means individually identifiable health information transmitted by electronic media or maintained in electronic media, including but not limited to electronic media as set forth under 45 CFR section 160.103.

F. Individually Identifiable Health Information means health information, including demographic information collected from an individual, that is created or received by a health care provider, health plan, employer or health care clearinghouse, and relates to the past, present or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, that identifies the individual or where there is a reasonable basis to believe the information can be used to identify the individual, as set forth under 45 CFR section 160.103.

G. Privacy Rule shall mean the HIPAA Regulation that is found at 45 CFR Parts 160 and 164.

H. Personal Information shall have the meaning given to such term in California Civil Code section 1798.29.

I. Protected Health Information means individually identifiable health information that is transmitted by electronic media, maintained in electronic media, or is transmitted or maintained in any other form or medium, as set forth under 45 CFR section 160.103.

J. Required by law, as set forth under 45 CFR section 164.103, means a mandate contained in law that compels an entity to make a use or disclosure of PHI that is enforceable in a court of law. This includes, but is not limited to, court orders and court-ordered warrants, subpoenas or summons issued by a court, grand jury, a governmental or tribal inspector general, or an administrative body authorized to require the production of information, and a civil or an authorized investigative demand. It also includes Medicare conditions of participation with respect to health care providers participating in the program, and statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing public benefits.

K. Secretary means the Secretary of the U.S. Department of Health and Human Services ("HHS") or the Secretary's designee.

L. Security Incident means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of PHI or PI, or confidential data that is essential to the ongoing operation of the Business Associate's organization and intended for internal use; or interference with system operations in an information system.

M. Security Rule shall mean the HIPAA regulation that is found at 45 CFR Parts 160 and 164.

N. Unsecured PHI shall have the meaning given to such term under the HITECH Act, 42 U.S.C. section 17932(h), any guidance issued pursuant to such Act, and the HIPAA regulations.

III. Terms of Agreement

A. Permitted Uses and Disclosures of PHI by Business Associate

Permitted Uses and Disclosures. Except as otherwise indicated in this Addendum, Business Associate may use or disclose PHI only to perform functions, activities or services specified in this Agreement, for, or on behalf of DHCS, provided that such use or disclosure would not violate the HIPAA regulations, if done by DHCS. Any such use or disclosure must, to the extent practicable, be limited to the limited data set, as defined in 45 CFR section 164.514(e)(2), or, if needed, to the minimum necessary to accomplish

Exhibit A
HIPAA Business Associate Addendum

the intended purpose of such use or disclosure, in compliance with the HITECH Act and any guidance issued pursuant to such Act, the HIPAA regulations, the Final Omnibus Rule and 42 CFR Part 2.

1. ***Specific Use and Disclosure Provisions.*** Except as otherwise indicated in this Addendum, Business Associate may:

   a. ***Use and disclose for management and administration.*** Use and disclose PHI for the proper management and administration of the Business Associate provided that such disclosures are required by law, or the Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and will be used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware that the confidentiality of the information has been breached.

   b. ***Provision of Data Aggregation Services.*** Use PHI to provide data aggregation services to DHCS. Data aggregation means the combining of PHI created or received by the Business Associate on behalf of DHCS with PHI received by the Business Associate in its capacity as the Business Associate of another covered entity, to permit data analyses that relate to the health care operations of DHCS.

B. Prohibited Uses and Disclosures

1. Business Associate shall not disclose PHI about an individual to a health plan for payment or health care operations purposes if the PHI pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full and the individual requests such restriction, in accordance with 42 U.S.C. section 17935(a) and 45 CFR section 164.522(a).

2. Business Associate shall not directly or indirectly receive remuneration in exchange for PHI, except with the prior written consent of DHCS and as permitted by 42 U.S.C. section 17935(d)(2).

C. Responsibilities of Business Associate

Business Associate agrees:

1. ***Nondisclosure.*** Not to use or disclose Protected Health Information (PHI) other than as permitted or required by this Agreement or as required by law.

2. ***Safeguards.*** To implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the PHI, including electronic PHI, that it creates, receives, maintains, uses or transmits on behalf of DHCS, in compliance with 45 CFR sections 164.308, 164.310 and 164.312, and to prevent use or disclosure of PHI other than as provided for by this Agreement. Business Associate shall implement reasonable and appropriate policies and procedures to comply with the standards, implementation specifications and other requirements of 45 CFR section 164, subpart C, in compliance with 45 CFR section 164.316. Business Associate shall develop and maintain a written information privacy and security program that includes administrative, technical and physical safeguards appropriate to the size and complexity of the Business Associate's operations and the nature and scope of its activities, and which incorporates the requirements of section 3, Security, below. Business Associate will provide DHCS with its current and updated policies.

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HIPAA Business Associate Addendum

3. ***Security.*** To take any and all steps necessary to ensure the continuous security of all computerized data systems containing PHI and/or PI, and to protect paper documents containing PHI and/or PI. These steps shall include, at a minimum:

   a. Complying with all of the data system security precautions listed in Attachment A, the Business Associate Data Security Requirements;

   b. Achieving and maintaining compliance with the HIPAA Security Rule (45 CFR Parts 160 and 164), as necessary in conducting operations on behalf of DHCS under this Agreement;

   c. Providing a level and scope of security that is at least comparable to the level and scope of security established by the Office of Management and Budget in OMB Circular No. A-130, Appendix III - Security of Federal Automated Information Systems, which sets forth guidelines for automated information systems in Federal agencies; and

   d. In case of a conflict between any of the security standards contained in any of these enumerated sources of security standards, the most stringent shall apply. The most stringent means that safeguard which provides the highest level of protection to PHI from unauthorized disclosure. Further, Business Associate must comply with changes to these standards that occur after the effective date of this Agreement.

   Business Associate shall designate a Security Officer to oversee its data security program who shall be responsible for carrying out the requirements of this section and for communicating on security matters with DHCS.

D. ***Mitigation of Harmful Effects.*** To mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate or its subcontractors in violation of the requirements of this Addendum.

E. ***Business Associate's Agents and Subcontractors.***

1. To enter into written agreements with any agents, including subcontractors and vendors, to whom Business Associate provides PHI or PI received from or created or received by Business Associate on behalf of DHCS, that impose the same restrictions and conditions on such agents, subcontractors and vendors that apply to Business Associate with respect to such PHI and PI under this Addendum, and that comply with all applicable provisions of HIPAA, the HITECH Act the HIPAA regulations, and the Final Omnibus Rule, including the requirement that any agents, subcontractors or vendors implement reasonable and appropriate administrative, physical, and technical safeguards to protect such PHI and PI. Business associates are directly liable under the HIPAA Rules and subject to civil and, in some cases, criminal penalties for making uses and disclosures of protected health information that are not authorized by its contract or required by law. A business associate also is directly liable and subject to civil penalties for failing to safeguard electronic protected health information in accordance with the HIPAA Security Rule. A "business associate" also is a subcontractor that creates, receives, maintains, or transmits protected health information on behalf of another business associate. Business Associate shall incorporate, when applicable, the relevant provisions of this Addendum into each subcontract or subaward to such agents, subcontractors and vendors, including the requirement that any security incidents or breaches of unsecured PHI or PI be reported to Business Associate.

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HIPAA Business Associate Addendum

2. In accordance with 45 CFR section 164.504(e)(1)(ii), upon Business Associate's knowledge of a material breach or violation by its subcontractor of the agreement between Business Associate and the subcontractor, Business Associate shall:

   a. Provide an opportunity for the subcontractor to cure the breach or end the violation and terminate the agreement if the subcontractor does not cure the breach or end the violation within the time specified by DHCS; or

   b. Immediately terminate the agreement if the subcontractor has breached a material term of the agreement and cure is not possible.

F. ***Availability of Information to DHCS and Individuals***. To provide access and information:

1. To provide access as DHCS may require, and in the time and manner designated by DHCS (upon reasonable notice and during Business Associate's normal business hours) to PHI in a Designated Record Set, to DHCS (or, as directed by DHCS), to an Individual, in accordance with 45 CFR section 164.524. Designated Record Set means the group of records maintained for DHCS that includes medical, dental and billing records about individuals; enrollment, payment, claims adjudication, and case or medical management systems maintained for DHCS health plans; or those records used to make decisions about individuals on behalf of DHCS. Business Associate shall use the forms and processes developed by DHCS for this purpose and shall respond to requests for access to records transmitted by DHCS within fifteen (15) calendar days of receipt of the request by producing the records or verifying that there are none.

2. If Business Associate maintains an Electronic Health Record with PHI, and an individual requests a copy of such information in an electronic format, Business Associate shall provide such information in an electronic format to enable DHCS to fulfill its obligations under the HITECH Act, including but not limited to, 42 U.S.C. section 17935(e).

3. If Business Associate receives data from DHCS that was provided to DHCS by the Social Security Administration, upon request by DHCS, Business Associate shall provide DHCS with a list of all employees, contractors and agents who have access to the Social Security data, including employees, contractors and agents of its subcontractors and agents.

G. ***Amendment of PHI.*** To make any amendment(s) to PHI that DHCS directs or agrees to pursuant to 45 CFR section 164.526, in the time and manner designated by DHCS.

H. ***Internal Practices***. To make Business Associate's internal practices, books and records relating to the use and disclosure of PHI received from DHCS, or created or received by Business Associate on behalf of DHCS, available to DHCS or to the Secretary of the U.S. Department of Health and Human Services in a time and manner designated by DHCS or by the Secretary, for purposes of determining DHCS' compliance with the HIPAA regulations. If any information needed for this purpose is in the exclusive possession of any other entity or person and the other entity or person fails or refuses to furnish the information to Business Associate, Business Associate shall so certify to DHCS and shall set forth the efforts it made to obtain the information.

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HIPAA Business Associate Addendum

I. ***Documentation of Disclosures***. To document and make available to DHCS or (at the direction of DHCS) to an Individual such disclosures of PHI, and information related to such disclosures, necessary to respond to a proper request by the subject Individual for an accounting of disclosures of PHI, in accordance with the HITECH Act and its implementing regulations, including but not limited to 45 CFR section 164.528 and 42 U.S.C. section 17935(c). If Business Associate maintains electronic health records for DHCS as of January 1, 2009, Business Associate must provide an accounting of disclosures, including those disclosures for treatment, payment or health care operations, effective with disclosures on or after January 1, 2014. If Business Associate acquires electronic health records for DHCS after January 1, 2009, Business Associate must provide an accounting of disclosures, including those disclosures for treatment, payment or health care operations, effective with disclosures on or after the date the electronic health record is acquired, or on or after January 1, 2011, whichever date is later. The electronic accounting of disclosures shall be for disclosures during the three years prior to the request for an accounting.

J. ***Breaches and Security Incidents.*** During the term of this Agreement, Business Associate agrees to implement reasonable systems for the discovery and prompt reporting of any breach or security incident, and to take the following steps:

1. ***Notice to DHCS.*** (1) To notify DHCS **immediately** upon the discovery of a suspected security incident that involves data provided to DHCS by the Social Security Administration. This notification will be **by telephone call plus email or fax** upon the discovery of the breach. (2) To notify DHCS **within 24 hours by email or fax** of the discovery of unsecured PHI or PI in electronic media or in any other media if the PHI or PI was, or is reasonably believed to have been, accessed or acquired by an unauthorized person, any suspected security incident, intrusion or unauthorized access, use or disclosure of PHI or PI in violation of this Agreement and this Addendum, or potential loss of confidential data affecting this Agreement. A breach shall be treated as discovered by Business Associate as of the first day on which the breach is known, or by exercising reasonable diligence would have been known, to any person (other than the person committing the breach) who is an employee, officer or other agent of Business Associate.

   Notice shall be provided to the DHCS Program Contract Manager, the DHCS Privacy Officer and the DHCS Information Security Officer. If the incident occurs after business hours or on a weekend or holiday and involves data provided to DHCS by the Social Security Administration, notice shall be provided by calling the DHCS EITS Service Desk. Notice shall be made using the "DHCS Privacy Incident Report" form, including all information known at the time. Business Associate shall use the most current version of this form, which is posted on the DHCS Privacy Office website (www.dhcs.ca.gov, then select "Privacy" in the left column and then "Business Use" near the middle of the page) or use this link:
   http://www.dhcs.ca.gov/formsandpubs/laws/priv/Pages/DHCSBusinessAssociatesOnly.aspx

   Upon discovery of a breach or suspected security incident, intrusion or unauthorized access, use or disclosure of PHI or PI, Business Associate shall take:

   a. Prompt corrective action to mitigate any risks or damages involved with the breach and to protect the operating environment; and

   b. Any action pertaining to such unauthorized disclosure required by applicable Federal and State laws and regulations.

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2. ***Investigation and Investigation Report.*** To immediately investigate such security incident, breach, or unauthorized access, use or disclosure of PHI or PI. If the initial report did not include all of the requested information marked with an asterisk, then within 72 hours of the discovery, Business Associate shall submit an updated "DHCS Privacy Incident Report" containing the information marked with an asterisk and all other applicable information listed on the form, to the extent known at that time, to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer:

3. ***Complete Report.*** To provide a complete report of the investigation to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer within ten (10) working days of the discovery of the breach or unauthorized use or disclosure. If all of the required information was not included in either the initial report, or the Investigation Report, then a separate Complete Report must be submitted. The report shall be submitted on the "DHCS Privacy Incident Report" form and shall include an assessment of all known factors relevant to a determination of whether a breach occurred under applicable provisions of HIPAA, the HITECH Act, the HIPAA regulations and/or state law. The report shall also include a full, detailed corrective action plan, including information on measures that were taken to halt and/or contain the improper use or disclosure. If DHCS requests information in addition to that listed on the "DHCS Privacy Incident Report" form, Business Associate shall make reasonable efforts to provide DHCS with such information. If necessary, a Supplemental Report may be used to submit revised or additional information after the completed report is submitted, by submitting the revised or additional information on an updated "DHCS Privacy Incident Report" form. DHCS will review and approve or disapprove the determination of whether a breach occurred, is reportable to the appropriate entities, if individual notifications are required, and the corrective action plan.

4. ***Notification of Individuals.*** If the cause of a breach of PHI or PI is attributable to Business Associate or its subcontractors, agents or vendors, Business Associate shall notify individuals of the breach or unauthorized use or disclosure when notification is required under state or federal law and shall pay any costs of such notifications, as well as any costs associated with the breach. The notifications shall comply with the requirements set forth in 42 U.S.C. section 17932 and its implementing regulations, including, but not limited to, the requirement that the notifications be made without unreasonable delay and in no event later than 60 calendar days. The DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer shall approve the time, manner and content of any such notifications and their review and approval must be obtained before the notifications are made.

5. ***Responsibility for Reporting of Breaches.*** If the cause of a breach of PHI or PI is attributable to Business Associate or its agents, subcontractors or vendors, Business Associate is responsible for all required reporting of the breach as specified in 42 U.S.C. section 17932 and its implementing regulations, including notification to media outlets and to the Secretary. If a breach of unsecured PHI involves more than 500 residents of the State of California or its jurisdiction, Business Associate shall notify the Secretary of the breach immediately upon discovery of the breach. If Business Associate has reason to believe that duplicate reporting of the same breach or incident may occur because its subcontractors, agents or vendors may report the breach or incident to DHCS in addition to Business Associate, Business Associate shall notify DHCS, and DHCS and Business Associate may take appropriate action to prevent duplicate reporting. The breach reporting requirements of this paragraph are in addition to the reporting requirements set forth in subsection 1, above.

6. ***DHCS Contact Information.*** To direct communications to the above referenced DHCS staff, the Contractor shall initiate contact as indicated herein. DHCS reserves the right to make changes to the

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contact information below by giving written notice to the Contractor. Said changes shall not require an amendment to this Addendum or the Agreement to which it is incorporated.

DHCS Program Contract Manager	DHCS Privacy Officer	DHCS Information Security Officer
See the Scope of Work exhibit for Program Contract Manager information	Privacy Officer c/o: Office of HIPAA Compliance Department of Health Care Services P.O. Box 997413, MS 4722 Sacramento, CA 95899-7413 Email: privacyofficer@dhcs.ca.gov Telephone: (916) 445-4646 Fax: (916) 440-7680	Information Security Officer DHCS Information Security Office P.O. Box 997413, MS 6400 Sacramento, CA 95899-7413 Email: iso@dhcs.ca.gov Fax: (916) 440-5537 Telephone: EITS Service Desk (916) 440-7000 or (800) 579-0874

K. ***Termination of Agreement.*** In accordance with Section 13404(b) of the HITECH Act and to the extent required by the HIPAA regulations, if Business Associate knows of a material breach or violation by DHCS of this Addendum, it shall take the following steps:

1. Provide an opportunity for DHCS to cure the breach or end the violation and terminate the Agreement if DHCS does not cure the breach or end the violation within the time specified by Business Associate; or
2. Immediately terminate the Agreement if DHCS has breached a material term of the Addendum and cure is not possible.

L. ***Due Diligence.*** Business Associate shall exercise due diligence and shall take reasonable steps to ensure that it remains in compliance with this Addendum and is in compliance with applicable provisions of HIPAA, the HITECH Act and the HIPAA regulations, and that its agents, subcontractors and vendors are in compliance with their obligations as required by this Addendum.

M. ***Sanctions and/or Penalties.*** Business Associate understands that a failure to comply with the provisions of HIPAA, the HITECH Act and the HIPAA regulations that are applicable to Business Associate may result in the imposition of sanctions and/or penalties on Business Associate under HIPAA, the HITECH Act and the HIPAA regulations.

IV. Obligations of DHCS

DHCS agrees to:

A. ***Notice of Privacy Practices.*** Provide Business Associate with the Notice of Privacy Practices that DHCS produces in accordance with 45 CFR section 164.520, as well as any changes to such notice. Visit the DHCS Privacy Office to view the most current Notice of Privacy Practices at: http://www.dhcs.ca.gov/formsandpubs/laws/priv/Pages/default.aspx or the DHCS website at www.dhcs.ca.gov (select "Privacy in the left column and "Notice of Privacy Practices" on the right side of the page).

B. ***Permission by Individuals for Use and Disclosure of PHI.*** Provide the Business Associate with any changes in, or revocation of, permission by an Individual to use or disclose PHI, if such changes affect the Business Associate's permitted or required uses and disclosures.

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C. ***Notification of Restrictions.*** Notify the Business Associate of any restriction to the use or disclosure of PHI that DHCS has agreed to in accordance with 45 CFR section 164.522, to the extent that such restriction may affect the Business Associate's use or disclosure of PHI.

D. ***Requests Conflicting with HIPAA Rules.*** Not request the Business Associate to use or disclose PHI in any manner that would not be permissible under the HIPAA regulations if done by DHCS.

V. Audits, Inspection and Enforcement

A. From time to time, DHCS may inspect the facilities, systems, books and records of Business Associate to monitor compliance with this Agreement and this Addendum. Business Associate shall promptly remedy any violation of any provision of this Addendum and shall certify the same to the DHCS Privacy Officer in writing. The fact that DHCS inspects, or fails to inspect, or has the right to inspect, Business Associate's facilities, systems and procedures does not relieve Business Associate of its responsibility to comply with this Addendum, nor does DHCS':

1. Failure to detect or

2. Detection, but failure to notify Business Associate or require Business Associate's remediation of any unsatisfactory practices constitute acceptance of such practice or a waiver of DHCS' enforcement rights under this Agreement and this Addendum.

B. If Business Associate is the subject of an audit, compliance review, or complaint investigation by the Secretary or the Office of Civil Rights, U.S. Department of Health and Human Services, that is related to the performance of its obligations pursuant to this HIPAA Business Associate Addendum, Business Associate shall notify DHCS and provide DHCS with a copy of any PHI or PI that Business Associate provides to the Secretary or the Office of Civil Rights concurrently with providing such PHI or PI to the Secretary. Business Associate is responsible for any civil penalties assessed due to an audit or investigation of Business Associate, in accordance with 42 U.S.C. section 17934(c).

VI. Termination

A. ***Term.*** The Term of this Addendum shall commence as of the effective date of this Addendum and shall extend beyond the termination of the contract and shall terminate when all the PHI provided by DHCS to Business Associate, or created or received by Business Associate on behalf of DHCS, is destroyed or returned to DHCS, in accordance with 45 CFR 164.504(e)(2)(ii)(I).

B. ***Termination for Cause.*** In accordance with 45 CFR section 164.504(e)(1)(ii), upon DHCS' knowledge of a material breach or violation of this Addendum by Business Associate, DHCS shall:

1. Provide an opportunity for Business Associate to cure the breach or end the violation and terminate this Agreement if Business Associate does not cure the breach or end the violation within the time specified by DHCS; or

2. Immediately terminate this Agreement if Business Associate has breached a material term of this Addendum and cure is not possible.

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C. ***Judicial or Administrative Proceedings.*** Business Associate will notify DHCS if it is named as a defendant in a criminal proceeding for a violation of HIPAA. DHCS may terminate this Agreement if Business Associate is found guilty of a criminal violation of HIPAA. DHCS may terminate this Agreement if a finding or stipulation that the Business Associate has violated any standard or requirement of HIPAA, or other security or privacy laws is made in any administrative or civil proceeding in which the Business Associate is a party or has been joined.

D. ***Effect of Termination.*** Upon termination or expiration of this Agreement for any reason, Business Associate shall return or destroy all PHI received from DHCS (or created or received by Business Associate on behalf of DHCS) that Business Associate still maintains in any form, and shall retain no copies of such PHI. If return or destruction is not feasible, Business Associate shall notify DHCS of the conditions that make the return or destruction infeasible, and DHCS and Business Associate shall determine the terms and conditions under which Business Associate may retain the PHI. Business Associate shall continue to extend the protections of this Addendum to such PHI, and shall limit further use of such PHI to those purposes that make the return or destruction of such PHI infeasible. This provision shall apply to PHI that is in the possession of subcontractors or agents of Business Associate.

VII. Miscellaneous Provisions

A. ***Disclaimer.*** DHCS makes no warranty or representation that compliance by Business Associate with this Addendum, HIPAA or the HIPAA regulations will be adequate or satisfactory for Business Associate's own purposes or that any information in Business Associate's possession or control, or transmitted or received by Business Associate, is or will be secure from unauthorized use or disclosure. Business Associate is solely responsible for all decisions made by Business Associate regarding the safeguarding of PHI.

B. ***Amendment.*** The parties acknowledge that federal and state laws relating to electronic data security and privacy are rapidly evolving and that amendment of this Addendum may be required to provide for procedures to ensure compliance with such developments. The parties specifically agree to take such action as is necessary to implement the standards and requirements of HIPAA, the HITECH Act, the HIPAA regulations and other applicable laws relating to the security or privacy of PHI. Upon DHCS' request, Business Associate agrees to promptly enter into negotiations with DHCS concerning an amendment to this Addendum embodying written assurances consistent with the standards and requirements of HIPAA, the HITECH Act, the HIPAA regulations or other applicable laws. DHCS may terminate this Agreement upon thirty (30) days written notice in the event:

1. Business Associate does not promptly enter into negotiations to amend this Addendum when requested by DHCS pursuant to this Section; or

2. Business Associate does not enter into an amendment providing assurances regarding the safeguarding of PHI that DHCS in its sole discretion, deems sufficient to satisfy the standards and requirements of HIPAA and the HIPAA regulations.

C. ***Assistance in Litigation or Administrative Proceedings.*** Business Associate shall make itself and any subcontractors, employees or agents assisting Business Associate in the performance of its obligations under this Agreement, available to DHCS at no cost to DHCS to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against DHCS, its directors, officers or employees based upon claimed violation of HIPAA, the HIPAA regulations or other laws relating to security and privacy, which involves inactions or actions by the Business Associate, except where Business Associate or its subcontractor, employee or agent is a named adverse party.

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D. ***No Third-Party Beneficiaries***. Nothing express or implied in the terms and conditions of this Addendum is intended to confer, nor shall anything herein confer, upon any person other than DHCS or Business Associate and their respective successors or assignees, any rights, remedies, obligations or liabilities whatsoever.

E. ***Interpretation***. The terms and conditions in this Addendum shall be interpreted as broadly as necessary to implement and comply with HIPAA, the HITECH Act, the HIPAA regulations and applicable state laws. The parties agree that any ambiguity in the terms and conditions of this Addendum shall be resolved in favor of a meaning that complies and is consistent with HIPAA, the HITECH Act and the HIPAA regulations.

F. ***Regulatory References***. A reference in the terms and conditions of this Addendum to a section in the HIPAA regulations means the section as in effect or as amended.

G. ***Survival.*** The respective rights and obligations of Business Associate under Section VI.D of this Addendum shall survive the termination or expiration of this Agreement.

H. ***No Waiver of Obligations***. No change, waiver or discharge of any liability or obligation hereunder on any one or more occasions shall be deemed a waiver of performance of any continuing or other obligation, or shall prohibit enforcement of any obligation, on any other occasion.

Exhibit A
HIPAA Business Associate Addendum

Attachment A
Business Associate Data Security Requirements

I. Personnel Controls

A. ***Employee Training.*** All workforce members who assist in the performance of functions or activities on behalf of DHCS, or access or disclose DHCS PHI or PI must complete information privacy and security training, at least annually, at Business Associate's expense. Each workforce member who receives information privacy and security training must sign a certification, indicating the member's name and the date on which the training was completed. These certifications must be retained for a period of six (6) years following contract termination.

B. ***Employee Discipline.*** Appropriate sanctions must be applied against workforce members who fail to comply with privacy policies and procedures or any provisions of these requirements, including termination of employment where appropriate.

C. ***Confidentiality Statement.*** All persons that will be working with DHCS PHI or PI must sign a confidentiality statement that includes, at a minimum, General Use, Security and Privacy Safeguards, Unacceptable Use, and Enforcement Policies. The statement must be signed by the workforce member prior to access to DHCS PHI or PI. The statement must be renewed annually. The Contractor shall retain each person's written confidentiality statement for DHCS inspection for a period of six (6) years following contract termination.

D. ***Background Check.*** Before a member of the workforce may access DHCS PHI or PI, a thorough background check of that worker must be conducted, with evaluation of the results to assure that there is no indication that the worker may present a risk to the security or integrity of confidential data or a risk for theft or misuse of confidential data. The Contractor shall retain each workforce member's background check documentation for a period of three (3) years following contract termination.

II. Technical Security Controls

A. ***Workstation/Laptop encryption.*** All workstations and laptops that process and/or store DHCS PHI or PI must be encrypted using a FIPS 140-2 certified algorithm which is 128bit or higher, such as Advanced Encryption Standard (AES). The encryption solution must be full disk unless approved by the DHCS Information Security Office.

B. ***Server Security.*** Servers containing unencrypted DHCS PHI or PI must have sufficient administrative, physical, and technical controls in place to protect that data, based upon a risk assessment/system security review.

C. ***Minimum Necessary.*** Only the minimum necessary amount of DHCS PHI or PI required to perform necessary business functions may be copied, downloaded, or exported.

D. ***Removable media devices.*** All electronic files that contain DHCS PHI or PI data must be encrypted when stored on any removable media or portable device (i.e. USB thumb drives, floppies, CD/DVD, smartphones, backup tapes etc.). Encryption must be a FIPS 140-2 certified algorithm which is 128bit or higher, such as AES.

E. ***Antivirus software.*** All workstations, laptops and other systems that process and/or store DHCS PHI or PI must install and actively use comprehensive anti-virus software solution with automatic updates scheduled at least daily.

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F. ***Patch Management.*** All workstations, laptops and other systems that process and/or store DHCS PHI or PI must have critical security patches applied, with system reboot if necessary. There must be a documented patch management process which determines installation timeframe based on risk assessment and vendor recommendations. At a maximum, all applicable patches must be installed within 30 days of vendor release.

G. ***User IDs and Password Controls.*** All users must be issued a unique user name for accessing DHCS PHI or PI. Username must be promptly disabled, deleted, or the password changed upon the transfer or termination of an employee with knowledge of the password, at maximum within 24 hours. Passwords are not to be shared. Passwords must be at least eight characters and must be a non-dictionary word. Passwords must not be stored in readable format on the computer. Passwords must be changed every 90 days, preferably every 60 days. Passwords must be changed if revealed or compromised. Passwords must be composed of characters from at least three of the following four groups from the standard keyboard:

- Upper case letters (A-Z)
- Lower case letters (a-z)
- Arabic numerals (0-9)
- Non-alphanumeric characters (punctuation symbols)

H. ***Data Destruction.*** When no longer needed, all DHCS PHI or PI must be cleared, purged, or destroyed consistent with NIST Special Publication 800-88, Guidelines for Media Sanitization such that the PHI or PI cannot be retrieved.

I. ***System Timeout.*** The system providing access to DHCS PHI or PI must provide an automatic timeout, requiring re-authentication of the user session after no more than 20 minutes of inactivity.

J. ***Warning Banners.*** All systems providing access to DHCS PHI or PI must display a warning banner stating that data is confidential, systems are logged, and system use is for business purposes only by authorized users. User must be directed to log off the system if they do not agree with these requirements.

K. ***System Logging.*** The system must maintain an automated audit trail which can identify the user or system process which initiates a request for DHCS PHI or PI, or which alters DHCS PHI or PI. The audit trail must be date and time stamped, must log both successful and failed accesses, must be read only, and must be restricted to authorized users. If DHCS PHI or PI is stored in a database, database logging functionality must be enabled. Audit trail data must be archived for at least 3 years after occurrence.

L. ***Access Controls.*** The system providing access to DHCS PHI or PI must use role based access controls for all user authentications, enforcing the principle of least privilege.

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M. ***Transmission encryption.*** All data transmissions of DHCS PHI or PI outside the secure internal network must be encrypted using a FIPS 140-2 certified algorithm which is 128bit or higher, such as AES. Encryption can be end to end at the network level, or the data files containing PHI can be encrypted. This requirement pertains to any type of PHI or PI in motion such as website access, file transfer, and E-Mail.

N. ***Intrusion Detection***. All systems involved in accessing, holding, transporting, and protecting DHCS PHI or PI that are accessible via the Internet must be protected by a comprehensive intrusion detection and prevention solution.

III. Audit Controls

A. ***System Security Review.*** All systems processing and/or storing DHCS PHI or PI must have at least an annual system risk assessment/security review which provides assurance that administrative, physical, and technical controls are functioning effectively and providing adequate levels of protection. Reviews should include vulnerability scanning tools.

B. ***Log Reviews.*** All systems processing and/or storing DHCS PHI or PI must have a routine procedure in place to review system logs for unauthorized access.

C. ***Change Control.*** All systems processing and/or storing DHCS PHI or PI must have a documented change control procedure that ensures separation of duties and protects the confidentiality, integrity and availability of data.

IV. Business Continuity / Disaster Recovery Controls

A. ***Emergency Mode Operation Plan.*** Contractor must establish a documented plan to enable continuation of critical business processes and protection of the security of electronic DHCS PHI or PI in the event of an emergency. Emergency means any circumstance or situation that causes normal computer operations to become unavailable for use in performing the work required under this Agreement for more than 24 hours.

B. ***Data Backup Plan.*** Contractor must have established documented procedures to backup DHCS PHI to maintain retrievable exact copies of DHCS PHI or PI. The plan must include a regular schedule for making backups, storing backups offsite, an inventory of backup media, and an estimate of the amount of time needed to restore DHCS PHI or PI should it be lost. At a minimum, the schedule must be a weekly full backup and monthly offsite storage of DHCS data.

V. Paper Document Controls

A. ***Supervision of Data.*** DHCS PHI or PI in paper form shall not be left unattended at any time, unless it is locked in a file cabinet, file room, desk or office. Unattended means that information is not being observed by an employee authorized to access the information. DHCS PHI or PI in paper form shall not be left unattended at any time in vehicles or planes and shall not be checked in baggage on commercial airplanes.

B. ***Escorting Visitors.*** Visitors to areas where DHCS PHI or PI is contained shall be escorted and DHCS PHI or PI shall be kept out of sight while visitors are in the area.

C. ***Confidential Destruction.*** DHCS PHI or PI must be disposed of through confidential means, such as cross cut shredding and pulverizing.

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D. ***Removal of Data.*** DHCS PHI or PI must not be removed from the premises of the Contractor except with express written permission of DHCS.

E. ***Faxing.*** Faxes containing DHCS PHI or PI shall not be left unattended and fax machines shall be in secure areas. Faxes shall contain a confidentiality statement notifying persons receiving faxes in error to destroy them. Fax numbers shall be verified with the intended recipient before sending the fax.

F. ***Mailing.*** Mailings of DHCS PHI or PI shall be sealed and secured from damage or inappropriate viewing of PHI or PI to the extent possible. Mailings which include 500 or more individually identifiable records of DHCS PHI or PI in a single package shall be sent using a tracked mailing method which includes verification of delivery and receipt, unless the prior written permission of DHCS to use another method is obtained.

DEPARTMENT OF HEALTH CARE SERVICES

HIPAA Business Associate Addendum

Attachment A

The following data files will be provided pursuant to this Agreement:

Managed Care Organization (MCO)

Each MCO will receive a list of Medi-Cal Participants (Participant) who received TCM services that is/was enrolled in that MCO. The list may provide the following information, as necessary, for each Participant who received TCM services:

1. Last Name
2. First Name
3. Middle Name
4. Date Of Birth
5. Sex
6. MEDS ID
7. LGA Name (Most recent LGA that provided care)
8. Program Type
9. Encounter Number
10. Date Of Service
11. California ID Number

Local Government Agency (LGA)

Each LGA will receive a list of Participants who received TCM services from the LGA. The list may provide the following information, as necessary, for each Participant who received TCM services:

1. Last Name
2. First Name
3. Middle Name
4. Date Of Birth
5. Sex
6. MEDS ID
7. LGA Name
8. Program Type
9. Encounter Number
10. Date Of Service
11. MCO Name (Most recent MCO that Participant is/was enrolled in)
12. California ID Number

MEDI-CAL PROVIDER AGREEMENT

(To Accompany Applications for Enrollment or Continued Enrollment)*

FOR STATE USE ONLY

Do not use staples on this form or on any attachments.
Type or print clearly in ink. If you must make corrections, please line through, date, and initial in ink.
Do not leave any questions, lines, etc. blank. Enter N/A if not applicable to you.

Date: 7 / 1 /2017

Legal name of applicant or provider (hereinafter jointly referred to as "Provider")	Business name (if different than legal name)		
COUNTY OF SHASTA	HEALTH AND HUMAN SERVICES AGENCY		
Provider number (NPI or Denti-Cal provider number as applicable)		Business Telephone Number	
1588709182		(530) 229-8400	
Business address (number, street)	City	State	Nine-digit ZIP code
1810 MARKET ST	REDDING	CA	96001-1930
Mailing address (number, street, P.O. Box number)	City	State	Nine-digit ZIP code
P.O. BOX 496005	REDDING	CA	96049-6005
Pay-to address (number, street, P.O. Box number)	City	State	Nine-digit ZIP code
P.O. BOX 496005	REDDING	CA	96049-6005
Previous business address (number, street, P.O. Box number)	City	State	Nine-digit ZIP code

Taxpayer Identification Number**
94-6000535

EXECUTION OF THIS PROVIDER AGREEMENT BETWEEN AN APPLICANT OR PROVIDER HEREINAFTER JOINTLY REFERRED TO AS "PROVIDER") AND THE DEPARTMENT OF HEALTH CARE SERVICES (HEREINAFTER "DHCS"), IS MANDATORY FOR PARTICIPATION OR CONTINUED PARTICIPATION AS A PROVIDER IN THE MEDI-CAL PROGRAM PURSUANT TO 42 UNITED STATES CODE, SECTION 1396a(a)(27), TITLE 42, CODE OF FEDERAL REGULATIONS, SECTION 431.107, WELFARE AND INSTITUTIONS CODE, SECTION 14043.2, AND TITLE 22, CALIFORNIA CODE OF REGULATIONS, SECTION 51000.30(a)(2).

AS A CONDITION FOR PARTICIPATION OR CONTINUED PARTICIPATION AS A PROVIDER IN THE MEDI-CAL PROGRAM, PROVIDER AGREES TO COMPLY WITH ALL OF THE FOLLOWING TERMS AND CONDITIONS, AND WITH ALL OF THE TERMS AND CONDITIONS INCLUDED ON ANY ATTACHMENT(S) HERETO, WHICH IS/ARE INCORPORATED HEREIN BY REFERENCE:

1. **Term and Termination.** This Agreement will be effective from the date applicant is enrolled as a provider by DHCS, or, from the date provider is approved for continued enrollment. Provider may terminate this Agreement by providing DHCS with written notice of intent to terminate, which termination shall result in Provider's immediate disenrollment and exclusion (without formal hearing under the Administrative Procedures Act) from further participation in the Medi-Cal program unless and until such time as Provider is re-enrolled by DHCS in the Medi-Cal program. DHCS may immediately terminate this Agreement for cause if Provider is suspended/excluded for any of the reasons set forth in Paragraph 26(a) below, which termination will result in Provider's immediate disenrollment and exclusion (without formal hearing under the Administrative Procedures Act) from further participation in the Medi-Cal program. During any period in which the provider is on provisional provider status or preferred provisional provider status, DHCS may terminate this agreement for any of the grounds stated in Welfare and Institutions Code Section 14043.27(c).

2. **Compliance With Laws and Regulations.** Provider agrees to comply with all applicable provisions of Chapters 7 and 8 of the Welfare and Institutions Code (commencing with Sections 14000 and 14200), and any applicable rules or regulations promulgated by DHCS pursuant to these Chapters. Provider further agrees that if it violates any of the provisions of Chapters 7 and 8 of the Welfare and Institutions Code, or any other regulations promulgated by DHCS pursuant to these Chapters, it may be subject to all sanctions or other remedies available to DHCS. Provider further agrees to comply with all federal laws and regulations governing and regulating Medicaid providers.

* Every applicant and provider must execute this Provider Agreement, except physicians, who must execute the "Medi-Cal Physician Application/Agreement," DHCS 6210.

** The taxpayer identification number may be a Taxpayer Identification Number (TIN) or a social security number for sole proprietors

3. **National Provider Identifier (NPI).** Provider agrees not to submit any claims to DHCS using an NPI unless that NPI is appropriately registered with the Centers for Medicare and Medicaid Services (CMS) and is in compliance with all NPI requirements established by CMS as of the date the claim is submitted. Provider agrees that submission of an NPI to DHCS as part of an application to use that NPI to obtain payment constitutes an implied representation that the NPI submitted is appropriately registered and in compliance with all CMS requirements at the time of submission. Provider also agrees that any subsequent defect in registration or compliance of the NPI constitutes an "addition or change in the information previously submitted" which must be reported to DHCS under the requirements of California Code of Regulations, title 22, section 51000.40.

4. **Forbidden Conduct.** Provider agrees that it shall not engage in conduct inimical to the public health, morals, welfare and safety of any Medi-Cal beneficiary, or the fiscal integrity of the Medi-Cal program.

5. **Nondiscrimination.** Provider agrees that it shall not exclude or deny aid, care, service or other benefits available under Medi-Cal or in any other way discriminate against a person because of that person's race, color, ancestry, marital status, national origin, gender, age, economic status, physical or mental disability, political or religious affiliation or beliefs in accordance with California and federal laws. Provider further agrees that it shall provide aid, care, service, or other benefits available under Medi-Cal to Medi-Cal beneficiaries in the same manner, by the same methods, and at the same scope, level, and quality as provided to the general public.

6. **Scope of Health and Medical Care.** Provider agrees that the health care services it provides may include diagnostic, preventive, corrective, and curative services, goods, supplies, and merchandise essential thereto, provided by qualified personnel for conditions that cause suffering, endanger life, result in illness or infirmity, interfere with capacity for normal activity, including employment, or for conditions which may develop into some significant handicap or disability. Provider further agrees such health care services may be subject to prior authorization to determine medical necessity.

7. **Licensing.** Provider agrees to possess at the time this Agreement becomes effective, and to maintain in good standing throughout the term of this Agreement, valid and unexpired license(s), certificate(s), or other approval(s) to provide health care services, which is appropriate to the services, goods, supplies, and merchandise being provided, if required by the state or locality in which Provider is located, or by the Federal Government. Provider further agrees that DHCS shall automatically suspend Provider as a provider in the Medi-Cal program pursuant to Welfare and Institutions Code, Section 14043.6, if Provider has license(s), certificate(s), or other approval(s) to provide health care services, which are revoked or suspended by a federal, California, or another state's licensing, certification, or approval authority, has otherwise lost that/those license(s), certificate(s), or approval(s), or has surrendered that/those license(s), certificate(s), or approval(s) while a disciplinary hearing on that/those license(s), certificate(s), or approval(s) was pending. Such suspension shall be effective on the date that Provider's license, certificate, or approval was revoked, suspended, lost, or surrendered. Provider further agrees to notify DHCS within ten business days of learning that any restriction has been placed on, or of a suspension of Provider's license, certificate, or other approval to provide health care. Provider further agrees to provide DHCS complete information related to any restriction to, or revocation or loss of, Provider's license, certificate, or other approval to provide health care services.

8. **Insurance.** Provider agrees to possess at the time this Agreement becomes effective, and to maintain in good standing throughout the term of this Agreement, liability insurance for the business address and, if a licensed practitioner, professional liability (malpractice) insurance coverage from an authorized insurer pursuant to Section 700 of the Insurance Code.

9. **Record Keeping and Retention.** Provider agrees to make, keep and maintain in a systematic and orderly manner, and have readily retrievable, such records as are necessary to fully disclose the type and extent of all services, goods, supplies, and merchandise provided to Medi-Cal beneficiaries, including, but not limited to, the records described in Section 51476 of Title 22, California Code of Regulations, and the records described in Section 431.107 of Title 42 of the Code of Federal Regulations. Provider further agrees that such records shall be made at or near the time at which the services, goods, supplies, and merchandise are delivered or rendered, and that such records shall be retained by Provider in the form in which they are regularly kept for a period of three years from the date the goods, supplies, or merchandise were delivered or the services rendered.

10. **DHCS, AG and Secretary Access to Records; Copies of Records.** Provider agrees to make available, during regular business hours, all pertinent financial records, all records of the requisite insurance coverage, and all records concerning the provision of health care services to Medi-Cal beneficiaries to any duly authorized representative of DHCS, the California Attorney General's Medi-Cal Fraud Unit ("AG"), and the Secretary of the United States Centers for Medicare and Medicaid Services (Secretary). Provider further agrees to provide, if requested by any of the above, copies of the records and documentation, and that failure to comply with any request to examine or receive copies of such records shall be grounds for immediate suspension of Provider from participation in the Medi-Cal program. Provider will be reimbursed for reasonable copy costs as determined by DHCS, AG or Secretary.

11. **Confidentiality of Beneficiary Information.** Provider agrees that all medical records of beneficiaries made or acquired by Provider shall be confidential and shall not be released without the written consent of the beneficiary or his/her personal representative, or as otherwise authorized by law.

12. **Disclosure of Information to DHCS.** Provider agrees to disclose all information as required in Federal Medicaid laws and regulations and any other information required by DHCS, and to respond to all requests from DHCS for information. Provider further agrees that the failure of Provider to disclose the required information, or the disclosure of false information shall, prior to any hearing, result in the denial of the application for enrollment or shall be grounds for termination of enrollment status or suspension from the Medi-Cal program, which shall include deactivation of all provider numbers used by Provider to obtain reimbursement from the Medi-Cal program. Provider further agrees that all bills or claims for payment to DHCS by Provider shall not be due and owing to Provider for any period(s) for which information was not reported or was reported falsely to DHCS. Provider further agrees to reimburse those Medi-Cal funds received during any period for which information was not reported, or reported falsely, to DHCS.

13. **Information Regarding Subcontractors and Suppliers.** Provider agrees to submit, within 35 days of the date on a request by the Secretary or the Medicaid agency, full and complete information about the ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-month period ending on the date of the request.

14. **Background Check.** Provider agrees that DHCS may conduct a background check on Provider for the purpose of verifying the accuracy of the information provided in the application and in order to prevent fraud or abuse. The background check may include, but not be limited to, the following: (1) on-site inspection prior to enrollment; (2) review of medical and business records; and, (3) data searches.

15. **Unannounced Visits By DHCS, AG and Secretary.** Provider agrees that DHCS, AG and/or Secretary may make unannounced visits to Provider, at any of Provider's business locations, before, during or after enrollment, for the purpose of determining whether enrollment, continued enrollment, or certification is warranted, to investigate and prosecute fraud against the Medi-Cal program, to investigate complaints of abuse and neglect of patients in health care facilities receiving payment under the Medi-Cal program, and/or as necessary for the administration of the Medi-Cal program and/or the fulfillment of the AG's powers and duties under Government Code Section 12528. Premises subject to inspection include billing agents, as defined in Welfare and Institutions Code Section 14040.1. Failure to permit inspection by DHCS, AG or Secretary or any agent, investigator or auditor thereof, shall be grounds for immediate suspension of provider from participation in the Medi-Cal program.

16. **Provider Fraud and Abuse.** Provider agrees that it shall not engage in or commit fraud or abuse. "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or herself or some other person. It includes any act that constitutes fraud under applicable federal or state law. "Abuse" means either: (1) practices that are inconsistent with sound fiscal or business practices and result in unnecessary cost to the Medicare program, the Medi-Cal program, another state's Medicaid program, or other health care programs operated, or financed in whole or in part, by the Federal Government or any state or local agency in this state or any other state; (2) practices that are inconsistent with sound medical practices and result in reimbursement by the Medi-Cal program or other health care programs operated, or financed in whole or in part, by the Federal Government or any state or local agency in this state or any other state, for services that are unnecessary or for substandard items or services that fail to meet professionally recognized standards for health care.

17. **Investigations of Provider for Fraud or Abuse.** Provider certifies that, at the time this Agreement was signed, it was not under investigation for fraud or abuse pursuant to Subpart A (commencing with Section 455.12) of Part 455 of Title 42 of the Code of Federal Regulations or under investigation for fraud or abuse by any other government entity. Provider further agrees to notify DHCS within ten business days of learning that it is under investigation for fraud or abuse. Provider further agrees that it shall be subject to temporary suspension pursuant to Welfare and Institutions Code, Section 14043.36(a), which shall include temporary deactivation of all provider numbers used by Provider to obtain reimbursement from the Medi-Cal program, if it is discovered by DHCS that Provider is under investigation for fraud or abuse. Provider further agrees to cooperate with and assist DHCS and any state or federal agency charged with the duty of identifying, investigating, sanctioning, or prosecuting suspected fraud and abuse.

18. **Provider Fraud or Abuse Convictions and/or Civil Fraud or Abuse Liability.** Provider certifies that it and its owners, officers, directors, employees, and agents, has not: (1) been convicted of any felony or misdemeanor involving fraud or abuse in any government program, within the last ten years; or (2) been convicted of any felony or misdemeanor involving the abuse of any patient; or (3) been convicted of any felony or misdemeanor substantially related to the qualifications, functions, or duties of a provider; or (4) entered into a settlement in lieu of conviction for fraud or abuse, within the last ten years; or, (5) been found liable for fraud or abuse in any civil proceeding, within the

last ten years. Provider further agrees that DHCS shall not enroll Provider if within the last ten years, Provider has been convicted of any felony or any misdemeanor involving fraud or abuse in any government program, has entered into a settlement in lieu of conviction for fraud or abuse, or has been found liable for fraud or abuse in any civil proceeding.

19. **Changes to Provider Information.** Provider agrees to keep its application for enrollment in the Medi-Cal program current by informing DHCS, Provider Enrollment Division, in writing on a form or forms to be specified by DHCS, within 35 days of any changes to the information contained in its application for enrollment, its disclosure statement, this Agreement, and/or any attachments to these documents.

20. **Prohibition of Rebate, Refund, or Discount.** Provider agrees that it shall not offer, give, furnish, or deliver any rebate, refund, commission preference, patronage dividend, discount, or any other gratuitous consideration, in connection with the rendering of health care services to any Medi-Cal beneficiary. Provider further agrees that it shall not solicit, request, accept, or receive, any rebate, refund, commission preference, patronage dividend, discount, or any other gratuitous consideration, in connection with the rendering of health care services to any Medi-Cal beneficiary. Provider further agrees that it will not take any other action or receive any other benefit prohibited by state or federal law.

21. **Payment From Other Health Coverage Prerequisite to Claim Submission.** Provider agrees that it shall first seek to obtain payment for services provided to Medi-Cal beneficiaries from any private or public health insurance coverage to which the beneficiary is entitled, where Provider is aware of this coverage and to the extent the coverage extends to these services, prior to submitting a claim to DHCS for the payment of any unpaid balance for these services. In the event that a claim submitted to a private or public health insurer has not been paid within 90 days of billing by Provider, Provider may submit a claim to DHCS.

22. **Beneficiary Billing.** Provider agrees that it shall not submit claims to or demand or otherwise collect reimbursement from a Medi-Cal beneficiary, or from other persons on behalf of the beneficiary, for any service included in the Medi-Cal program's scope of benefits in addition to a claim submitted to the Medi-Cal program for that service, except to: (1) collect payments due under a contractual or legal entitlement pursuant to Welfare and Institutions Code, Section 14000(b); (2) bill a long-term care patient for the amount of his/her liability; and, (3) collect a co-payment pursuant to Welfare and Institutions Code, Sections 14134 and 14134.1. Provider further agrees that, in the event that a beneficiary willfully refuses to provide current other health care coverage billing information as described in Section 50763(a)(5) of Title 22, California Code of Regulations, Provider may, upon giving the beneficiary written notice of intent, bill the beneficiary as a private pay patient.

23. **Payment From Medi-Cal Program Shall Constitute Full Payment.** Provider agrees that payment received from DHCS in accordance with Medi-Cal fee structures shall constitute payment in full, except that Provider, after making a full refund to DHCS of any Medi-Cal payments received for services, goods, supplies, or merchandise, may recover all of Provider's fees to the extent that any other contractual entitlement, including, but not limited to, a private group or indemnification insurance program, is obligated to pay the charges for the services, goods, supplies, or merchandise provided to the beneficiary.

24. **Return of Payment for Services Otherwise Covered by the Medi-Cal Program.** Provider agrees that any beneficiary who has paid Provider for health care services, goods, supplies, or merchandise otherwise covered by the Medi-Cal program received by the beneficiary shall be entitled to a prompt return from Provider of any part of the payment which meets any of the following: (1) was rendered during any period prior to the receipt of the beneficiary's Medi-Cal card, for which the card authorizes payment under Welfare and Institutions Code, Sections 14018 or 14019; (2) was reimbursed to Provider by the Medi-Cal program, following audits and appeals to which Provider is entitled; (3) is not payable by a third party under contractual or other legal entitlement; (4) was not used by the beneficiary to satisfy his/her paid or obligated liability for health care services, goods, supplies, or merchandise, or to establish eligibility.

25. **Compliance With Billing and Claims Requirements.** Provider agrees that it shall comply with all of the billing and claims requirements set forth in the Welfare and Institutions Code and its implementing regulations, and the provider manual.

26. **Deficit Reduction Act of 2005, Section 6032 Implementation.** As a condition of payment for services, goods, supplies and merchandise provided to beneficiaries in the Medical Assistance Program ("Medi-Cal"), providers must comply with the False Claims Act employee training and policy requirements in 1902(a) of the Social Security Act (42 USC 1396a(a)(68)), set forth in that subsection and as the federal Secretary of Health and Human Services may specify.

27. **Termination of Provisional Provider or Preferred Provisional Provider Status.** Provider agrees that, while it is on provisional provider status or preferred provisional provider status, the provider will be subject to immediate termination of its provisional provider status or preferred provisional provider status and disenrollment from the Medi-Cal program in the following circumstances:

(1) The provider, persons with an ownership or control interest in the provider, or persons who are directors, officers, or managing employees of the provider have been convicted of any felony, or convicted of any misdemeanor involving fraud or abuse in any government program, related to neglect or abuse of a patient in connection with the delivery of a health care item or service, or in connection with the interference with, or obstruction of, any investigation into health care related fraud or abuse, or have been found liable for fraud or abuse in any civil proceeding, or have entered into a settlement in lieu of conviction for fraud or abuse in any government program within 10 years of the date of the application package.

(2) There is a material discrepancy in the information provided to the department, or with the requirements to be enrolled, that is discovered after provisional provider status or preferred provisional provider status has been granted and that cannot be corrected because the discrepancy occurred in the past.

(3) The provider has provided material information that was false or misleading at the time it was provided.

(4) The provider failed to have an established place of business at the business address for which the application package was submitted at the time of any onsite inspection, announced or unannounced visit, or any additional inspection or review conducted pursuant to this article or a statute or regulation governing the Medi-Cal program, unless the practice of the provider's profession or delivery of services, goods, supplies, or merchandise is such that services, goods supplies, or merchandise are rendered or delivered at locations other than the business address and this practice of delivery of services, goods, supplies, or merchandise has been disclosed in the application package approved by the department when the provisional provider status of preferred provisional provider status was granted.

(5) The provider meets the definition of a clinic under Section 1200 of the Health and Safety Code, but is not licensed as a clinic pursuant to Chapter 1 (commencing with Section 1200) of Division 2 of the Health and Safety Code and fails to meet the requirements to qualify for at least one exemption pursuant to Section 1206 or 1206.1 of the Health and Safety Code.

(6) The provider performs clinical laboratory tests or examinations, but it or its personnel do not meet CLIA, and the regulations adopted thereunder, and the state clinical laboratory law, do not possess valid CLIA certificates and clinical laboratory registrations or licenses pursuant to Chapter 3 (commencing with Section 1200) of Division 2 of the Business and Professions Code, or are not exempt from licensure as a clinical laboratory under Section 1241 of the Business and Professions Code.

(7) The provider fails to possess either of the following:

(a) The appropriate licenses, permits, certificates, or other approvals needed to practice the profession or occupation, or provide the services, goods, supplies, or merchandise the provider identified in the application package approved by the department when the provisional provider status or preferred provisional provider status was granted and for the location for which the application was submitted.

(b) The business or zoning permits or other approval necessary to operate a business at the location identified in its application package approved by the department when the provisional provider status or preferred provisional provider status was granted.

(8) The provider, or if the provider is a clinic, group, partnership, corporation, or other association, any officer, director, or shareholder with a 10 percent or greater interest in that organization, commits two or more violations of the federal or state statues or regulation governing the Medi-Cal program, and the violations demonstrate a pattern or practice of fraud, abuse, or provision of unnecessary or substandard medical services.

(9) The provider commits any violation of a federal or state statute or regulation governing the Medi-Cal program or of a statute or regulation governing the provider's profession or occupation and the violation represents a threat of immediate jeopardy or significant harm to any Medi-Cal beneficiary or to the public welfare.

(10) The provider submits claims for payment that subject a provider to suspension under Section 14043.61.

(11) The provider submits claims for payment for services, goods, supplies, or merchandise rendered at a location other than the location for which the provider number was issued, unless the practice of the provider's profession or delivery of services, goods, supplies, or merchandise is such that services, goods, supplies, or merchandise

are rendered or delivered at locations other than the business address and this practice or delivery of services, goods, supplies, or merchandise has been disclosed in the application package approved by the department when the provisional provider status was granted.

(12) The provider has not paid its fine, or has a debt due and owing, including overpayments and penalty assessments, to any federal, state, or local government entity that relates to Medicare, Medicaid, Medi-Cal, or any other federal or state health care program, and has not made satisfactory arrangements to fulfill the obligation or otherwise been excused by legal process from fulfilling the obligation.

28. **Provider Suspension; Appeal Rights; Reinstatement.** Provider agrees that it is to be subject to the following suspension actions. Provider further agrees that the suspension by DHCS of Provider shall include deactivation of all of Provider's provider numbers and shall preclude Provider from submitting claims for payment, either personally or through claims submitted by any individual, clinic, group, corporation, or other association to the Medi-Cal program for any services, supplies, goods, or merchandise that provider has provided directly or indirectly to a Medi-Cal beneficiary, except for services, supplies, goods, or merchandise provided prior to the suspension.

a. **Automatic Suspensions/Mandatory Exclusions.** DHCS shall automatically suspend Provider under the following circumstances:

(1) Upon notice from the Secretary of the United States Department of Health and Human Services that Provider has been excluded from participation in the Medicare or Medicaid programs. No administrative appeal of a suspension on this ground shall be available to Provider. (Welfare and Institutions Code, Section 14123(b),(c).)

(2) If Provider has license(s), certificate(s), or other approval(s) to provide health care services, revoked or suspended by a federal, California, or another state's licensing, certification, or approval authority, has otherwise lost that/those license(s), certificate(s), or approval(s), or has surrendered that/those license(s), certificate(s), or approval(s) while a disciplinary hearing on that license, certificate, or approval was pending. (Welfare and Institutions Code, Section 14043.6.)

(3) If Provider is convicted of any felony or any misdemeanor involving fraud, abuse of the Medi-Cal program or any patient, or otherwise substantially related to the qualifications, functions, or duties of a provider of service. Suspension following conviction is not subject to the proceedings under Welfare and Institutions Code, Section 14123(c). However, the director may grant an informal hearing at the request of the provider to determine in the director's sole discretion if the circumstances surrounding the conviction justify rescinding or otherwise modifying the suspension.

b. **Permissive Suspensions/Permissive Exclusions.** DHCS may suspend Provider under the following circumstances:

(1) Provider violates any of the provisions of Chapter 7 of the Welfare and Institutions Code (commencing with Section 14000 except for Sections 14043–14044), or Chapter 8 (commencing with Section 14200) or any rule or regulations promulgated by DHCS pursuant to those provisions. Administrative appeal pursuant to Health and Safety Code, Section 100171. (Welfare and Institutions Code, Section 14123(a),(c).)

(2) Provider fails to comply with DHCS' request to examine or receive copies of the books and records pertaining to services rendered to Medi-Cal beneficiaries. Administrative appeal pursuant to Health and Safety Code, Section 100171. (Welfare and Institutions Code, Section 14124.2.)

(3) Provider participating in the Medi-Cal dental program provides services, goods, supplies, or merchandise that are below or less than the standard of acceptable quality, as established by the California Dental Association Guidelines for the Assessment of Clinical Quality and Professional Performance, Copyright 1995, Third Edition, as periodically amended. (Welfare and Institutions Code, Section 14123(f).)

c. **Temporary Suspension.** DHCS shall temporarily suspend Provider under the following circumstances:

(1) Provider fails to disclose all information as required in federal Medicaid regulations or any other information required by DHCS, or discloses false information. Administrative appeal pursuant to Welfare and Institutions Code, Section 14043.65. (Welfare and Institutions Code, Section 14043.2(a).)

(2) If it is discovered that Provider is under investigation for fraud or abuse. Administrative appeal pursuant to Welfare and Institutions Code, Section 14043.65. (Welfare and Institutions Code, Section 14043.36(a).)

(3) Provider fails to remediate discrepancies discovered as a result of an unannounced visit to Provider. Administrative appeal pursuant to Welfare and Institutions Code, Section 14043.65. (Welfare and Institutions Code, Section 14043.7(c).)

(4) When necessary to protect the public welfare or the interests of the Medi-Cal program. Administrative appeal pursuant to Health and Safety Code, Section 100171. (Welfare and Institutions Code, Section14123(c).)

(5) Provider submits claims for payment under any provider number from an individual or entity that is suspended, excluded or otherwise ineligible. This includes a provider on the Suspended and Ineligible Provider List or any list published by the Office of the Inspector General or the Department of Health and Human Services. Appeal pursuant to Welfare and Institutions Code, Section 14043.65. (Welfare and Institutions Code, Section 14043.61)

29. **Liability of Group Providers.** Provider agrees that, if it is a provider group, the group, and each member of the group, are jointly and severally liable for any breach of this Agreement, and that action by DHCS against any of the providers in the provider group may result in action against all of the members of the provider group.

30. **Legislative and Congressional Changes.** Provider agrees that this Agreement is subject to any future additional requirements, restrictions, limitations, or conditions enacted by the California Legislature or the United States Congress which may affect the provisions, terms, conditions, or funding of this Agreement in any manner.

31. **Provider Capacity.** Provider agrees that Provider, and the officers, directors, employees, and agents of Provider, in the performance of this Agreement, shall act in an independent capacity and not as officers or employees or agents of the State of California.

32. **Indemnification.** Provider agrees to indemnify, defend, and save harmless the State of California, its officers, agents, and employees, from any and all claims and losses accruing or resulting to any and all persons, firms, or corporations furnishing or supplying services, materials, or supplies in connection with Provider's performance of this Agreement, and from any and all claims and losses accruing or resulting to any Medi-Cal beneficiary, or to any other person, firm, or corporation who may be injured or damaged by Provider in the performance of this Agreement.

33. **Governing Law.** This Agreement shall be governed by and interpreted in accordance with the laws of the State of California.

34. **Venue.** Venue for all actions, including federal actions, concerning this Agreement, lies in Sacramento County, California, or in any other county in which the California Department of Justice maintains an office.

35. **Titles.** The titles of the provisions of this Agreement are for convenience and reference only and are not to be considered in interpreting this Agreement.

36. **Severability.** If one or more of the provisions of this Agreement shall be invalid, illegal, void, or unenforceable, the validity, legality, and enforceability of the remaining provisions shall not in any way be affected or impaired. Either party having knowledge of such a provision shall promptly inform the other of the presumed nonapplicability of such provision. Should the nonapplicable provision go to the heart of this Agreement, the Agreement shall be terminated in a manner commensurate with the interests of both parties.

37. **Assignability.** Provider agrees that it has no property right in or to its status as a Provider in the Medi-Cal program or in or to the provider number(s) assigned to it, and that Provider may not assign its provider number for use as a Medi-Cal provider, or any rights and obligations it has under this Agreement except to the extent purchasing owner is joining this provider agreement with successor liability with joint and several liability.

38. **Waiver.** Any action or inaction by DHCS or any failure of DHCS on any occasion, to enforce any right or provision of this Agreement, shall not be interpreted to be a waiver by DHCS of its rights hereunder and shall not prevent DHCS from enforcing such provision or right on any future occasion. The rights and remedies of DHCS herein are cumulative and are in addition to any other rights or remedies that DHCS may have at law or in equity.

39. **Complete Integration.** This Agreement, including any attachments or documents incorporated herein by express reference, is intended to be a complete integration and there are no prior or contemporaneous different or additional agreements pertaining to the subject matter of this Agreement.

40. **Amendment.** No alteration or variation of the terms or provisions of this Agreement shall be valid unless made in writing and signed by the parties to this Agreement, and no oral understanding or agreement not set forth in this Agreement, shall be binding on the parties to this Agreement.

41. **Provider Attestation.** Provider agrees that all information it submits on the application form for enrollment, this Agreement, and all attachments or changes to either, is true, accurate, and complete to the best of Provider's knowledge and belief. Provider further agrees to sign the application form for enrollment, this Agreement, and all attachments or changes to either, under penalty of perjury under the laws of the State of California.

Provider agrees that compliance with the provisions of this agreement is a condition precedent to payment to provider.

The parties agree that this agreement is a legal and binding document and is fully enforceable in a court of competent jurisdiction. The provider signing this agreement warrants that he/she has read this agreement and understands it.

I declare under penalty of perjury under the laws of the State of California that the foregoing information is true, accurate, and complete to the best of my knowledge and belief.

I declare I am the provider or I have the authority to legally bind the provider, which is an entity and not an individual person and that I am eligible to sign this agreement under Title 22, CCR Section 51000.30(a)(2)(B).

1. Printed legal name of provider

COUNTY OF SHASTA

2. Printed name of person signing this declaration on behalf of provider (if an entity or business name is listed in Item 1 above)

DAVID A. KEHOE

3. Original signature of provider or representative if this provider is an entity other than an individual person as sole proprietor

David A. Kehoe

4. Title of person signing this declaration

CHAIRMAN, BOARD OF SUPERVISORS, COUNTY OF SHASTA

5. Executed at: Redding (City), CA (State) on / / (Date)

6. Notary Public:

Applicants and providers licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act, or the Chiropractic Initiative Act ARE NOT REQUIRED to have this form notarized. If notarization is required, the Certificate of Acknowledgement signed by the Notary Public must be in the form specified in Section 1189 of the Civil Code.

Privacy Statement
(Civil Code Section 1798 et seq.)

All information requested on the application, the disclosure statement, and the provider agreement is mandatory with the exception of the social security number for any person other than the person or entity for whom an IRS Form 1099 must be provided by the Department pursuant to 26 USC 6041. This information is required by the Department of Health Care Services, Provider Enrollment Division, by the authority of Welfare and Institutions Code Section 14043.2(a). The consequences of not supplying the mandatory information requested are denial of enrollment as a Medi-Cal provider or denial of continued enrollment as a provider and deactivation of all provider numbers used by the provider to obtain reimbursement from the Medi-Cal program. The consequence of not supplying the voluntary social security number information requested is delay in the application process while other documentation is used to verify the information supplied. Any information provided will be used to verify eligibility to participate as a provider in the Medi-Cal program. Any information may also be provided to the State Controller's Office, the California Department of Justice, the Department of Consumer Affairs, the Department of Corporations, or other state or local agencies as appropriate, fiscal intermediaries, managed care plans, the Federal Bureau of Investigation, the Internal Revenue Service, Medicare Fiscal Intermediaries, Centers for Medicare and Medicaid Services, Office of the Inspector General, Medicaid, and licensing programs in other states. For more information or access to records containing your personal information maintained by this agency, contact the Provider Enrollment Division at (916) 323-1945 or Denti-Cal at (800) 423-0507.

ACKNOWLEDGMENT

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California
County of SHASTA)

On June 20, 2017 before me, Jennifer A. Duval, Notary Public
(insert name and title of the officer)

personally appeared David A. Kehoe,
who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____ (Seal)

JENNIFER A. DUVAL
Notary Public – California
Shasta County
Commission # 2185779
My Comm. Expires Apr 5, 2021

MEDI-CAL PROVIDER AGREEMENT

(To Accompany Applications for Enrollment or Continued Enrollment)*

Additional Signatures

ATTEST:

LAWRENCE G. LEES
Clerk of the Board of Supervisors

By: _____
Deputy

Approved as to form:
RUBEN E. CRUSE, JR
County Counsel

By: _____ 6/7/17
Alan B. Cox
Deputy County Counsel

RISK MANAGEMENT APPROVAL

By: _____ 06/08/17
James Johnson
Risk Management Analyst

INFORMATION TECHNOLOGY APPROVAL

By: _____ 6-8-2017
Tom Schreiber
Chief Information Officer

Information Exchange Agreement
Between
The Social Security Administration (SSA)
And
The California Department of Health Care Services (State Agency)
has been redacted due to confidentiality.

To request a copy, contact BSS Contracts and reference Contract ID #
2127-30-2017-01 or Clerk of the Board.

ATTACHMENT B

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 17 — 037

2. STATE: California

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: July 1, 2017

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ■ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION
Section 1915(g)(1) Social Security Act

7. FEDERAL BUDGET IMPACT
a. FFY 2017-18 $ 521,148
b. FFY 2018-19 $ 521,148

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Supplement 1e To Attachment 3.1-a Page 1

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Supplement 1e To Attachment 3.1-a Page 1

10. SUBJECT OF AMENDMENT
Targeted Case Management - Individuals in Jeopardy of Negative Health or Psycho-Social Outcomes

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
■ OTHER, AS SPECIFIED

12. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

13. TYPED NAME
Mari Cantwell

14. TITLE
State Medicaid Director

15. DATE SUBMITTED
9/25/2017

16. RETURN TO
Department of Health Care Services
Attn: State Plan Coordinator
1501 Capitol Avenue, Suite 71.3.26
P.O. Box 997417
Sacramento, CA 95899-7417

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED
September 25, 2017

18. DATE APPROVED
December 7, 2017

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2017

20. SIGNATURE OF REGIONAL OFFICIAL
[redacted]

21. TYPED NAME
Henrietta Sam-Louie

22. TITLE
Associate Regional Administrator, Division of Medicaid & Children's Health Operations

23. REMARKS

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: CALIFORNIA

TARGETED CASE MANAGEMENT SERVICES
INDIVIDUALS IN JEOPARDY OF NEGATIVE HEALTH OR PSYCHO-SOCIAL OUTCOMES

Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441 .18(a)(9)):
Medi-Cal eligible individuals, who have been determined to be in jeopardy of negative health or psycho-social outcomes due to one of the following disparity factors:

a) Substance abuse in the immediate environment, or
b) History of, or in danger of family violence, or
c) History of or in danger of physical, sexual or emotional abuse, or
d) Experiencing substandard housing, or
e) Illiteracy; and

Such individuals must be in need of assistance in accessing necessary medical, social, educational, or other services, when comprehensive case management is not being provided elsewhere.

For those individuals in this target group, who may receive case management services under a waiver program, case management services shall not be duplicated, in accordance with Section 1915(g) of the Social Security Act. This target group excludes persons enrolled in a Home and Community-Based Services waiver program from receipt of Targeted Case Management (TCM) services.

There shall be a county-wide system to ensure coordination among TCM providers of case management services provided to Medi-Cal beneficiaries who are eligible to receive case management services from two or more programs.

Areas of State in which services will be provided (§1915(g)(1) of the Act):
__Entire State.
__X__Only in the following geographic areas: Counties of Alameda, Butte, Contra Costa, El Dorado, Humboldt, Imperial, Kern, Kings, Lake, Los Angeles, Madera, Monterey, Napa, Orange, Placer, Riverside, San Diego, San Luis Obispo, San Mateo, Santa Clara, Santa Cruz, Shasta, Solano, Sonoma, Stanislaus, Sutter, Trinity, Tuolumne, Ventura,Yuba, City of Berkeley, and City of Long Beach.

Comparability of Services (§§1902(a)(10)(B) and 1915(g)(1))
_ Services are provided in accordance with Section 1902(a)(10)(B) of the Act.
X Services are not comparable in amount, duration, and scope (§ 1915(g)(1))

Definition of Services: (42 CFR 440.169): Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:

1. Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include:

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- Taking client history;
- Identifying the individual's needs and completing related documentation; and
- Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;

Assessment and/or periodic reassessment to be conducted at a minimum of once every six months to determine if an individual's needs, conditions, and/or preferences, have changed.

2. Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that:
   - Specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
   - Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
   - Identifies a course of action to respond to the assessed needs of the eligible individual;

3. Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including:
   - Activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan;

4. Monitoring and follow-up activities:
   - Activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
     - o Services are being furnished in accordance with the individual's care plan;
     - o Services in the care plan are adequate; and
     - o Changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

   Periodic Reviews will be completed at least every six months. These activities may be conducted as specified in the care plan, or as frequently as necessary to ensure execution of the care plan.

   Monitoring does not include ongoing evaluation or check-in of an individual when all care plan goals have been met.

X Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's nee9s. (42 CFR 440.169(e))

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Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):

TCM Provider Agency Qualifications:

- Establish a system to coordinate services for individuals who may be covered under another program which offers components of case management or coordination similar to TCM including, but not limited to, the coordination of services with Managed Care providers, California Children's Services, as well as State waiver programs (e.g. HIV/AIDS, etc.).
- Demonstrated programmatic and administrative experience in providing comprehensive case management services and the ability to increase their capability to provide their services to the target group; and
- Must be an agency employing staff with case management qualifications; and
- Establish referral systems and demonstrated linkages and referral ability with essential social and health service agencies; and
- Have a minimum of five years providing comprehensive case management services to the target group; and
- Administrative capacity to ensure quality of services in accordance with state and federal requirements; and
- Financial management capacity and system that provides documentation of services and costs in accordance with OMB A-87 principles; and
- Capacity to document and maintain individual case records in accordance with state and federal requirements; and
- Demonstrated ability to meet state and federal requirements tor documentation, billing and audits; and
- Ability to evaluate the effectiveness, accessibility, and quality of TCM services on a community-wide basis.

TCM Case Manager Qualifications: Case managers employed by the case management agency must meet the requirements for education and/or experience as defined below:

- A Registered Nurse, or a Public Health Nurse with a license in active status to practice as a registered nurse in California; individual shall have met the educational and clinical experience requirements as defined by the California Board of Registered Nursing, or
- An individual with at least a Bachelor's degree from an accredited college or university, who has completed an agency-approved case management training course, or
- An individual with at least an Associate of Arts degree from an accredited college, who has completed an agency-approved case management training course and has two years of experience performing case management duties in the health or human services field, or
- An individual who has completed an agency-approved case management training course and has four years of experience performing case management duties in a health or human services field.

Freedom of choice (42 CFR 441.18(a)(1):

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

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1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Access to Services (42 CFR 441.18(a)(2). 42 CFR 441.18(a)(3). 42 CFR 441.18(a)(6):
The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4)):
Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records (42 CFR 441.'18(a)(7)):
Providers maintain case records that document for all individuals receiving case management as follows: (i)The name of the individual; (ii) The dates of the case management services; (iii) The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

Limitations:
Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in § 440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and FFP is not available in expenditures for, services defined in § 440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.1S(c))

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FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

Limitations on translation: Arranging for translation activities and/or providing translation as part of the TCM service, including the costs of purchasing translation services from a vendor to enable communication between the client and case manager, is included in the TCM rate. When a case manager provides translation that is unrelated to providing the TCM service, the translation is not claimable as TCM.

Case Management Services Do Not Include:

- Program activities of the agency itself that do not meet the definition of TCM,
- Administrative activities necessary for the operation of the agency providing case management services rather than the overhead costs directly attributable to targeted case management,
- Diagnostic and/or treatment services,
- Restricting or limiting access to services, such as through prior authorization,
- Activities that are an essential part of Medicaid administration, such as outreach, intake processing, eligibility determination, or claims processing,
- Services that are an integral part of another service already reimbursed by Medicaid,
- Matching children to placement alternatives, assess complaints of alleged child abuse or neglect; coordinate activities with law enforcement and the legal and court systems, hearing preparation, filing of petitions, providing counseling, parenting training, or substance abuse testing.

ATTACHMENT C

Shasta LGA
Performance Monitoring Plan

Background

Payment for case management services under Section 1915(g) of the Social Security Act may not duplicate payments made to public agencies or private entities under other program authorities for the same purposes. In general, payment may not be made for services for which another payer is liable. Payment may not be made for services for which no payment liability is incurred. Similarly, separate payment cannot be made for similar services, which are an integral and inseparable part of another Medicaid covered service.

Medi-Cal is the payor of last resort. Anytime a Medi-Cal covered service is also being provided by a non-Medi-Cal program, the provision of services must default to the non-Medi-Cal provider.

Purpose

The performance monitoring plan is a countywide system that ensures coordination among providers of Targeted Case Management (TCM) services provided to beneficiaries who are eligible to receive case management services from two or more programs. Duplication of case management services may occur regardless of the payer of the program, i.e., case management services reimbursed through Medi-Cal and/or a Medi-Cal payer may occur among and is not limited to any of the TCM beneficiary groups.

The specific objectives of the performance monitoring plan are:

- To prevent duplication of services when a single Medi-Cal client receives identical Service Plan referrals and follow-up from more than one case manager.
- To coordinate among providers of case management services to beneficiaries who are eligible to receive case management services from two or more programs.
- To ensure coordination of services and continuity of care.

Definitions

Duplication occurs when a Medi-Cal client receives case management services from two or more TCM programs and the services provided are for the same purpose at the same time. For example, it is duplication of services when a single Medi-Cal client receives identical case management services, including Service Plan referrals and follow-up, from more than one case manager.

It is not considered duplication when a client has more than one case manager and only one case manager assumes the role of lead case manager. The lead case manager must be responsible for

communicating with the other case managers when developing, implementing, and monitoring a client's Service Plan. The case managers must communicate regularly relative to the service needs of their mutual TCM client.

Policy

The case manager will ascertain and document in the case file if the client is receiving TCM services from other agencies or programs regardless of the funding source. If the client is receiving other services, the case manager will document the name of the other agencies or programs. The case manager will document the nature and extent of the services provided by the other agencies or programs. The lead and other case managers will communicate regularly to determine which services are most appropriately provided by their respective agencies and/or programs.

The Performance Monitoring Plan will be centrally located and a copy will be available to Department of Health Care Services (DHCS) and Centers for Medicare and Medicaid Services (CMS) staff upon request.

Procedures

The procedure to ascertain if a client is receiving services from other case management agencies and/or programs is the responsibility of the case manager providing TCM services and must be regularly reviewed on a case-by-case basis. Procedures are based on client declaration.

Identification of Potential Duplication of Case Management Services

Client Declaration Procedure

As part of the initial TCM assessment, the TCM case manager will ask the client "Is anyone else helping you with _____ (any of the needs identified through the TCM assessment)? The TCM program will rely on client declaration.

If the needs identified during the TCM assessment are not being addressed by other providers, then duplication does not exist. The TCM case manager will document in the client's file "Client states no other provider is addressing the identified needs."

If the needs identified during the TCM assessment are being addressed by other providers, then duplication may exist. The TCM case manager will document in the client's file "Client states he/she is receiving assistance from (name of providers) for (specify needs such as job training etc.)." In this case scenario, there are two options:

1. The TCM case manager and the TCM Service Plan would not address the need; or

2. The TCM case manager would coordinate with the other provider. See Case Management Service Coordination below.

Case Management Service Coordination

When a Medi-Cal client states that a TCM identified need is being addressed by another provider, the TCM case manager must determine whether potential duplication of case management services exists. If the TCM case manager is familiar with the level of services offered by the other provider and is confident that the client's needs will be met, then those needs can be excluded from the TCM Service Plan.

If the TCM case manager is not familiar with or confident of the services offered by the other provider, case management service coordination is required to address the potential duplication of services. The TCM case manager must determine the nature and extent of the case management services offered by the other provider. Several procedures may be considered to address case management service coordination.

1. Phone verification of the case management services offered by the other provider(s).

   The TCM case manager will phone the other provider to determine the nature and extent of case management services provided to the client. This information will be documented in the client's case file.

   If it appears that the client's needs are being adequately met, the TCM case manager will not address those needs in the TCM Service Plan. Again, this information will be documented in the client's case file.

2. Interagency or Interdepartmental Case Conferences

   When two or more agencies that generally address different needs (e.g., Public Health and Public Guardian or CalWORKs-employment and AFLP-schooling and parenting) are working with the same client, it may be advisable to conduct an initial and periodic case conference. The case conference will delineate the areas of need to be addressed by each entity and ensure coordination and continuity of care. The TCM case manager will document in the case file that a case conference has occurred and that the needs included in the TCM Service Plan are not being addressed by other providers.

3. Collaborative Case Management

   When more than one case manager is involved, the objectives of the Service Plan are achieved through an organized, collaborative mode of case management in which each member of the interdisciplinary team has responsibility for service activities in their area of expertise. One lead case manager must maintain primary responsibility for assuring coordination of the functions of case management and service provision to ensure non-duplication of services. An interdisciplinary case conference will be held periodically, at which time the client's service providers shall provide information regarding the client's status and continuing need for services. A review of the Service Plan and evaluation of the services the client is receiving will be reviewed, as well as the client's current status. Appropriate documentation will be maintained in the client file, including the names and

titles of those participating in the case conference, relevant information discussed, and whether the client or legal representative had input into the conference.

4. TCM Audit File Documentation of Services Offered by other Case Management Providers

   If the TCM program serves clients that are regularly served by other providers of case management services within Shasta County, the lead case manager will meet with the coordinator(s) of those other programs to determine an agreed upon division of responsibilities regarding case management. Any agreements and/or discussion must be documented and included in the TCM Audit File.

   Once it has been established that different providers will address different client needs within Shasta County when the TCM client is being served by one or more of these providers, the TCM program can address the remaining needs without duplication occurring.

5. Periodic Review

   TCM Case Managers shall conduct a periodic audit of randomly selected TCM case files to ensure that the case file documentation is in compliance with the Shasta LGA Performance Monitoring Plan.