NO WITHHOLDING

AGREEMENT BETWEEN
THE COUNTY OF SHASTA AND
PRIME HEALTHCARE SERVICES - SHASTA, LLC.

This agreement is entered into by, and between the County of Shasta, a political subdivision of the State of California, through its Health and Human Services Agency, and, Prime Healthcare Services - Shasta, LLC a Delaware corporation, registered to do business in the State of California, hereinafter referred to as "Provider" (collectively, the "Parties" and individually a "Party"). For the purposes of this agreement, the County of Shasta and Shasta County Health and Human Services Agency shall be referred to collectively as "County."

COUNTY OF SHASTA

ATTEST:

LAWRENCE G. LEES
Clerk of the Board
of Supervisors

By _____
DEPUTY

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

Approved as to form:

RUBIN E. CRUSE, JR
County Counsel

By: _____
Alan B. Cox
Deputy County Counsel

RISK MANAGEMENT APPROVAL

By: _____
James Johnson
Risk Management Analyst

PROVIDER

Date _____

By_____
Casey Fatch, CEO

Federal Tax Identification No. On File

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ARTICLE I
DEFINITIONS

A. **General Meaning of Words and Terms**.

The words and terms used in this agreement are intended to have their usual meanings unless a particular or more limited meaning is associated with their usage under the provisions of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code (Section 14000 et seq.) and/or Titles 9 and 22 of the California Code of Regulations pertaining to the rendition of health care or unless specifically defined in this Article I or otherwise in this agreement.

B. **Beneficiary**.

1. Beneficiary shall mean any person certified pursuant to the Welfare and Institutions Code, sections 14016 and 14018, as eligible for Medi-Cal and whose Beneficiary I.D. Number contains Shasta County Code Number 45 as the first two numbers, except that Beneficiary shall not include Medi-Cal beneficiaries enrolled in prepaid health plans or other Managed Care Systems which contract with the State of California Department of Health Services under the provisions of Chapter 7 of Part 3 of Division 9 (sections 14000, et seq.) of the Welfare and Institutions Code and the regulations adopted under Title 22 of the California Code of Regulations.

2. Beneficiary may also include any person whose eligibility for Medi-Cal was not determined until after the rendition of services by Provider or any person admitted to Provider's facility ("Facility"), either voluntarily or involuntarily pursuant to the Lanterman-Petris-Short Act (the "LPS Act," Part 1 of Division 5 of the Welfare and Institutions Code, commencing at section 5000).

3. A Medi-Cal Beneficiary who is also eligible for Medicare hospital benefits under the provisions of Title XVIII of the Social Security Act, (42 U.S.C. §1395c et seq.), and who has not exhausted those benefits, is not considered a Beneficiary within the meaning of this agreement.

4. Beneficiary does not include those persons receiving skilled nursing facility or long-term care services.

C. **Inpatient Psychiatric Services**.

1. Inpatient Psychiatric Services includes, but is not limited to, the following services when ordered by a Beneficiary's responsible physician or other qualified health practitioner and rendered in accordance with Title 22 of the California Code of Regulations to a Beneficiary, subject, however, to such exclusions, limitations, exceptions, and conditions as are otherwise set forth in any provision of this agreement or any Exhibit hereto:

   a. Semi-private room accommodations including bed, board, and related services.

   b. 24-hour nursing care.

   c. Pharmaceuticals.

   d. Dietary.

   e. Physical and mental examination for assessment and diagnosis - technical component.

   f. Crisis intervention services.

   g. Administration and supervision of the clinical use of psychotropic medications.

   h. Individual and group psychotherapy.

i. Art, recreational, and vocational therapy.

j. Clinical laboratory services.

k. Social services.

l. Services of psychiatrist and/or psychologist under contract by Provider for a Short-Doyle Indigent.

m. Services of psychiatrist and/or psychologist not included in the provisions for managed Medi-Cal Beneficiaries.

n. Supplies, appliances, and equipment.

D. **Plan**.

Plan refers to the Inpatient Managed Care Plan of the State of California that consolidates the dual private Fee-For-Service and public Short-Doyle/Medi-Cal System into a single coordinated service system administered by Shasta County.

E. **Claim**.

Claim shall mean a claim for compensation filed by Provider in accordance with Medi-Cal policy and procedures as specified in Title 22, California Code of Regulations; the State Fiscal Intermediary Provider Manual and Bulletins; and as specified by Shasta County.

F. **County**.

County means the County of Shasta, a political subdivision of the State of California, and shall be deemed to include the Shasta County Health and Human Services Agency.

G. **State**.

State shall mean the State of California Department of Health Care Services.

H. **Delegate**.

Delegate means any natural or corporate person to whom Provider, by contract or otherwise, transfers or assigns the responsibility to perform any covenant assumed by Provider in this agreement.

I. **Administrative Day**.

Administrative day shall mean any day of care in an acute care facility for which medical necessity is not present for acute inpatient care reimbursement and there is no safe lower level of care available to which the patient could be transferred to as approved by Shasta County.

J. **Fiscal Intermediary**.

Fiscal intermediary means that person(s) or entity who/that has contracted as specified in section 14104.3 of the Welfare and Institutions Code with the State of California Department of Health Care Services to perform fiscal intermediary services related to this agreement.

K. **Provider**.

Provider shall mean Prime Healthcare Services – Shasta, LLC a Delaware corporation registered to do business in the State of California.

L. **Shall**.

Shall is used to specify an obligation of either County or Provider and denotes a mandatory function or direction.

M. **May**.

May is used to indicate a permissive or discretionary term or function.

N. **Emergency Services**.

Emergency Services mean those services provided to an individual, which are necessary to screen and treat a medical condition that shows itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical care could be reasonably expected to result in one of the following:

a. Placing the individual's health, or, with respect to a pregnant woman, her health or her unborn child's health, in serious jeopardy.

b. Serious impairment to bodily function or serious dysfunction of any bodily organ or part.

c. With respect to a pregnant woman who is having contractions, Emergency Services includes those medical services which are necessary to effectuate a safe delivery of the child while protecting the health of the pregnant woman, when there is inadequate time to affect a safe transfer to another hospital or facility before delivery or when a transfer may threaten the health or safety of the pregnant woman or the unborn child.

Emergency Services includes emergency screening and stabilizing treatment that the Provider is required to provide in accordance with state and federal law.

O. **Medically Necessary**.

Medically Necessary shall mean medical services that are:

1. Determined to be appropriate and necessary for the symptoms, diagnosis, or treatment of the medical conditions of a Beneficiary.

2. Provided for the diagnosis or care and treatment of a Beneficiary's medical condition.

3. Within the standards of the Provider and medical practice within the community. Medically Necessary services include Emergency Services.

P. Short-Doyle refers to the Short-Doyle/Bronzan-McCorquodale Act, Part 2 of Division 5 (commencing with section 5600) of the Welfare and Institutions Code.

ARTICLE II
HOSPITAL PERFORMANCE PROVISIONS

A. **Services Provided by Provider**.

1. In accordance with the terms and conditions of this agreement, Provider shall provide, 24 hours per day and 7 days per week, Inpatient Psychiatric Services to Beneficiaries subject to the availability of space in Provider's Facility.

2. For all Inpatient Psychiatric Services provided pursuant to this agreement, Provider assumes full responsibility for the provision of those Inpatient Psychiatric services in accordance with Part 2.5 of Division 5 (commencing at section 5775) and Article 5 of Chapter 8.8 of Part 3 of Division 9 (commencing at section 14680) of the Welfare and Institutions Code, and all regulations adopted pursuant thereto, through a delegate, or as otherwise provided in this agreement. For all Inpatient Psychiatric Services provided pursuant to this agreement, Provider agrees to accept as payment in full those payments made to Provider in accordance with Article IV and **EXHIBIT NO. 1**, attached and incorporated herein, of this agreement. County agrees to pay Provider for Inpatient Psychiatric Services rendered in accordance with the terms and conditions of Article IV and **EXHIBIT NO. 1** of this agreement.

3. Provider shall at its own expense provide and maintain facilities and professional, allied, and supportive medical and paramedical personnel to provide all necessary and appropriate Inpatient Psychiatric Services in accordance with this agreement.

4. Provider shall at its own expense provide and maintain the organizational administrative capabilities to carry out its duties and responsibilities under this agreement and all applicable statutes and regulations pertaining to Medi-Cal providers.

5. Provider agrees that it has secured or shall secure at its own expense all persons, employees and equipment required to perform the services required under this agreement, and that all such services shall be performed by Provider, or under Provider's supervision, by persons authorized by law to perform such services.

6. For the purposes of Article II.A.1 of this agreement, "Beneficiaries," means any individual who meets the criteria for a Medi-Cal Beneficiary without reference to residence, domicile, or any other geographic factor and as provided in Article I.B. of this agreement.

7. For the purposes of Article II.A.2 of this agreement, "all Inpatient Psychiatric Services" means the services specified in Article I.C. of this agreement, and Emergency Services means the services specified in Article I.N. of this agreement.

8. For all Inpatient Psychiatric Services provided pursuant to this agreement, Provider agrees services will include access to medical treatment and up-to-date psychopharmacology, transportation to needed off-site services, and bilingual/bicultural programming.

    a. Services shall include, but are not limited to 72-hour detention under Welfare and Institutions Code ("WIC") Section 5150, 14-day Certification under WIC Section 5250 and 30-day Certification under WIC Section 5270 (and acute psychiatric inpatient care for voluntary Beneficiaries who would otherwise be referred by County).

    b. Provider will prepare and serve all Notices of Certification under WIC Sections 5250 et. seq. or 5256 et. seq. and conduct all necessary certification and capacity hearings as provided for in WIC Section 5250 et. seq. and Section 5332 et. seq. Patient's Rights Advocates to be served all required notices no later than 3:00 p.m. the day preceding any

hearing described herein where practical, otherwise when reasonable able to do so and in accordance with all laws.

B. **Licensing and Certification**.

1. Provider hereby represents and warrants that it is currently, and for the duration of this agreement shall remain, licensed as a general acute care hospital or acute psychiatric hospital in accordance with Chapter 2 of Division 2 of the Health and Safety Code (commencing at section 1250) and the licensing regulations contained in Titles 22 and 17 of the California Code of Regulations.

2. Provider hereby represents and warrants that is it currently, and for the duration of this agreement shall remain, certified under Title XVIII of the Social Security Act (commencing at 42 U.S.C. section 1395).

3. Provider agrees to comply with its obligation to remain licensed as a general acute care hospital or acute psychiatric hospital as provided in Article II.B.1. of this agreement and to remain certified under Title XVIII of the Social Security Act as provided in Article II.B.2. of this agreement.

4. Provider and Provider'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.

5. With respect to Provider's Site(s), Provider shall comply with all applicable County, state and federal licensing requirements and shall obtain all applicable licenses and display the same in a location on Provider's Site(s) that is reasonably conspicuous. Failure to maintain the licensing requirements shall be deemed a breach of this agreement and may be, at County's sole discretion, grounds for the termination of this agreement pursuant to Article VIII.B. of this agreement.

6. Provider shall immediately advise County of any investigation or adverse action taken against it, or its principals, partners, officers, employees, subcontractors, and agent providing services pursuant to this agreement by state or federal agencies and/or professional licensing organizations.

C. **Services Neither Covered Nor Compensated**.

1. Provider shall not be obligated to provide Beneficiaries with, and County shall not be obligated to compensate Provider for the following services pursuant to this agreement (services not covered under County's allocations from the State):

   a. Services rendered under the State of California Children's Services Program that are not reimbursable under the State's Medi-Cal program.

   b. Dental services, as defined in Title 22, California Code of Regulations, section 51059.

   c. Long-term care institutional services.

   d. Outpatient services.

D. **Availability of Services**.

1. Provider shall not differentiate nor discriminate in the treatment of Medi-Cal beneficiaries, nor shall Provider discriminate on the basis of race, color, creed, religion, national origin, sex, physical or mental disability, age, marital status, or sexual orientation.

2. Provider shall render services to Beneficiaries in the same manner and in accordance with the same time availability as offered to Provider's other patients except as limited by existing Medi-Cal restrictions.

3. Provider shall retain the right, within its sole discretion, to alter, enlarge, reconstruct, modify, or shut down all or any part of its Facility provided, however, that written notice of any action described herein which would materially affect the services available to Beneficiaries under this agreement, shall be given to County at least 30 days prior to implementation of such change, and County shall maintain the right to terminate this agreement without cause upon providing Provider with 30 days prior written notice from the date in which notice was received by County of such change.

E. **County Not to Interfere with Provider**.

Provider and County acknowledge that County's responsibilities under this agreement and governing legislation and regulations, do not create a right for County to interfere in treatment methods or methodologies used by Provider or by treating or attending physicians providing services under this agreement provided that such services are rendered in accordance with this agreement and with governing laws and regulations. Provider shall operate as an independent contractor as described in Article XII.E. of this agreement.

F. **Utilization Controls**.

County shall not be obligated to pay Provider for any services provided to a Beneficiary pursuant to this agreement unless Provider adheres to all utilization controls and obtains authorization for services in accordance with Medi-Cal policy and procedures as prescribed in Title 22 of the California Code of Regulations and in the State Fiscal Intermediary Provider Manual and bulletins.

G. **Services Authorization**.

1. Provider and County acknowledge that County's responsibilities under this agreement and under governing legislation and regulations require that, except when Emergency Services are being provided, Provider consult with County concerning individuals who may be eligible for Psychiatric Inpatient Services under the terms of this agreement. Therefore, in order to exercise its responsibilities (both under this agreement and pursuant to legislation and regulations,) County requires that Provider consult with County concerning individuals not referred to Provider by County so that County can determine whether criteria for Medically Necessary services (as defined in Article I.O., of this agreement), appropriateness of admission, length of proposed services, and other determinants as defined in funding legislation and regulations and as described in Article III of this agreement have been met.

2. Provider shall provide such consultation by contacting County prior to admission of an individual whom Provider believes is eligible for, and in need of, services under this agreement, in all cases (except emergency admission) in which County’s staff is not the source of the referral.

H. **Utilization Controls Compliance by Provider as Condition Precedent to County Payment Obligation**.

As a condition precedent to any County payment obligation under the terms of this agreement, Provider shall adhere to County's Quality Management Plan including utilization controls, State of California Department of Health Care Services (or any other subsequent applicable state agency) Letters and Notices,

as well as subdivision (g) of section 5777 of the Welfare and Institutions Code and regulations adopted pursuant thereto.

I. **Appointments of Liaisons and Agency Status**.

1. Provider shall designate in writing a person to act as liaison to County. Such person shall coordinate all communications between the Parties.

2. County shall designate a liaison in conformity with procedures and with such authority as specified in Article X.C. of this agreement. Communications to County shall be submitted by the Provider to the Shasta County Health and Human Services Agency ("HHSA") Director ("Director") or any HHSA Branch Director designated by the HHSA Director at the following address: Shasta County Health and Human Services Agency, P.O. Box 496005, Redding, CA, 96049-6005.

3. Comply with WIC section 5608(b) regarding the exercise of general supervision of mental health services in Shasta County by the local director of mental health services under Part 2 of Division 5 of the Welfare and Institutions Code.

J. **Service Locations**.

Inpatient Psychiatric services rendered by Provider pursuant to this agreement shall be rendered at the following Facility:

Shasta Regional Medical Center
1100 Butte Street
Redding, CA 96001

K. **Quality of Care**.

1. As a condition precedent to any payment by County to Provider under the terms of this agreement, whether performance pursuant to this agreement is by the Provider directly or by a delegate as permitted herein, Provider shall:

a. Assure that any and all eligible Beneficiaries receive care as required by Part 2.5 of Division 5 (commencing at section 5777) and Article 5 of Chapter 8.8 of Part 3 of Division 9 (commending at section 14680) of the Welfare and Institutions Code.

b. Take such actions as required by Provider's Medical Staff Bylaws against Medical Staff members who violate those Bylaws.

c. Provide Inpatient Psychiatric Services in the same manner to Beneficiaries as it provides to all patients to whom it renders Inpatient Psychiatric Services.

d. Not discriminate against Beneficiaries in any manner including admission practices and placement in special wings or rooms, nor make any provision for special or separate meals unless medically necessary.

L. **Payment in Full**.

Whether rendered directly or through the instrumentality of a delegate as permitted under this agreement, Provider shall bear the total cost of Inpatient Psychiatric Services rendered to each Beneficiary covered in

this agreement. This means that Provider covenants to accept as payment in full for the Inpatient Psychiatric Services described herein, the payments made by County pursuant to Article IV. of this agreement.

M. **Quality Assurance**.

1. Provider shall notify County of any and all adverse incidents involving a Patient, including, but not limited to, death or injury. All adverse incidents are reviewed by County and any recommendations will be forwarded both to the HHSA Director, or his/her designee, and the Provider's Administrator, or his/her designee.

2. Provider shall furnish County with a copy of its current Quality Assurance Policies and Procedures and its Client Problem Resolution Process within 30 days of execution of this agreement.

ARTICLE III
PROGRAMMATIC/ADMISSION PROVISIONS

A. **Goals and Objectives of Plan**.

The goal of County's Inpatient Local Managed Mental Health Care Plan (the "Plan") is to assure Beneficiary access to quality coordinated mental health services and the avoidance of service duplication and unnecessary costs. The objective, whenever clinically appropriate, is to divert Beneficiaries into community-based services.

B. **Contact Prior to Admission**.

Provider shall contact Shasta County Transitions, Admissions and Discharge Team ("TAD Team") for authorization prior to any planned admission to Provider's Facility pursuant to this agreement. In the cases of admissions for Emergency Services, Provider shall obtain from County authorization within 10 calendar days of said admission. This contact can be initiated by telephone to the TAD Team at (530) 225-5204.

C. **Outpatient Consideration**.

Before authorizing an admission to the Facility, Provider shall provide, at County's request, an assessment as to the reason why the Beneficiary cannot be treated at a lower level of care, i.e., outpatient services.

D. **Agreement for Admission**.

1. A Treatment Authorization Request ("TAR") Form 18-3 must be completed and submitted to County via FAX (530-225-5950) or courier so that it is received prior to expiration of the first 48 hours of admission, and medical records must be forwarded to County pursuant to Article III.G. of this agreement. When Provider and County have agreed that admission to the Facility is appropriate, County agrees to provide full payment for services for the first 48 hours of admission except when medical necessity is not established due to insufficient or illegible documentation. In the event a TAR Form 18-3 is not approved by County due to insufficient or illegible documentation, County will not be liable for payment for any hours of admission up to and including the first 48 hours of admission.

2. Ensure all documentation of medical necessity is in compliance with all State requirements and in accordance with CCR Title 9 sections 1820.205 and 1820.225.

3. Comply with CCR Title 9, section 1820.225 when an Out-of-County Client is placed in Provider's facility, and report monthly to County the number of Out-of-County Clients discharged within Shasta County and the number discharged to other counties.

E. **Consultative/Retrospective Review**.

Following the initial 48 hours of admission, County's personnel shall consult with Provider on the need for ongoing Inpatient Psychiatric Services and/or transfer to County for ongoing and/or follow-up services. This consultation does not imply payment. Questions concerning such consultations can be forwarded to the County's Managed Care Program. Payment authorization, if required under this agreement, will occur retrospectively upon discharge.

F. **Discharge Planning**.

1. A key component of the Plan is to assure that Beneficiaries avoid future hospitalizations. In this regard, it is essential that County and Provider work collaboratively to develop a quality discharge strategy. Upon being informed of a Planned Discharge, Provider shall contact the TAD Team as soon as Beneficiary is determined by Facility to be ready for discharge within 24 hours to

coordinate discharge planning with County. Regarding Unplanned Discharges, Provider shall make all best efforts to contact TAD Team as soon as Beneficiary is determined by Facility to be ready for discharge.

2. Provider shall keep County and TAD Team fully informed of all discharges to include, but not be limited to; standard discharges, 5150 holds, Reese Hearings and writs of Habeas Corpus. Provider shall inform County of all discharge times and dates as Provider becomes aware and shall update County should these times and/or dates change.

G. **Beneficiary's Medical Record/Treatment Authorization Request**.

1. Provider must provide County with legible copies of the following medical records and TAR forms for each discharged Beneficiary no later than 14 calendar days from the date of discharge for each admission:

   a. Comprehensive psychiatric evaluation.

   b. M.D. orders.

   c. Treatment plan.

   d. Progress notes.

   e. Discharge plan.

   f. Any other clinical information that Provider deems appropriate.

2. Failure of Provider to provide the aforementioned medical records and the TAR forms in a legible format and within 14 calendar days of discharge date may result in all charges for the Beneficiary's dates of service for that admission being denied in total on retrospective review.

H. **State Regulations**.

Nothing in this Article (Article III) is intended to supersede the Medi-Cal Psychiatric Inpatient Hospital Services Consolidation Emergency Regulations of the State of California Department of Health Care Services (or any other subsequent appropriate state agency).

I. **Beneficiaries Age 21 and Under**.

In compliance with legal requirements of *Emily Q. v. Bonta* [C.D.Cal.,2001,CV 98-4181], Provider shall provide a copy of the brochure describing the Early and Periodic Screening, Diagnosis, and Treatment program and entitled "Medi-Cal Services for Children and Young People: Early and Periodic Screening, Diagnosis, and Treatment Mental Health Services" and a copy of the Therapeutic Behavioral Services notice entitled "Medi-Cal Services for Children and Young People: Therapeutic Behavioral Services" to all full-scope Medi-Cal Beneficiaries under 21 years of age admitted to Provider's Facility pursuant to this agreement, as well as their legal representatives. It is the responsibility of Provider to ensure that sufficient numbers of these notices are available at the Facility at all times.

For information on how to obtain these notices, Provider shall contact County's Managed Care Program by telephone at (530) 245-6750.

J. **Designated Inpatient Units.**

Provider shall at minimum, maintain the community standard of Shasta County LPS designated inpatient mental health units regarding the average number of facilitated therapeutic treatment groups offered per

day based on the type of population served, which is for adult units, 6 groups; and older adult units, 5 groups.

K. **Quarterly Reports**

Submit quarterly status reports, attached and incorporated herein as **EXHIBIT NO. 6, QUARTERLY REPORT** to County during the term of this agreement for each Beneficiary placed in the Facility. For purposes of this agreement, quarterly shall mean no later than 20 days after the end of each calendar quarter (i.e., January 15, April 15, July 15, and October 15) during the time this agreement is in effect.

L. **Program Integrity Requirements**.

Provider shall:

1. Comply with all state and federal statutory and regulatory requirements for certification of claims including Title 42, Code of Federal Regulations (CFR) Part 438.

2. For each Beneficiary, for whom Contractor is submitting a claim for reimbursement assure the following:

    a. An assessment of the Beneficiary was conducted in compliance with the requirements established in the State Plan.

    b. The Beneficiary was eligible to receive Medi-Cal services at the time the services were provided to the Beneficiary.

    c. The services included in the claim were actually provided to the Beneficiary.

    d. Medical necessity was established for the Beneficiary as defined by statute and/or regulation for the service or services provided, for the timeframe in which the services were provided, except for the initial assessment and when County decides to keep a Beneficiary at the Provider's facility as allowed by regulation.

    e. A client plan was developed and maintained for the Beneficiary that met all client plan requirements as set forth in the State Plan.

3. In addition, Provider certifies the following processes are in place:

    a. Written policies, procedures, and standards of conduct that articulate Contractor's commitment to comply with all applicable federal and state standards.

    b. The designation of a compliance officer and a compliance committee who/that are accountable to Contractor's senior management.

    c. Effective training and education for the compliance officer, compliance committee, and the Contractor's employees.

    d. Enforcement of standards through well-publicized employee disciplinary guidelines.

    e. Internal auditing and monitoring.

    f. Prompt response to detected offenses, and development of corrective action initiatives relating to the provision of mental health services.

ARTICLE IV
PAYMENT PROCEDURE

A. **Coordination of Benefits**.

Provider shall use reasonable efforts to collect monies due and owing for Covered Services (CS) provided to a Beneficiary, from the Federal Medicare program, and from private health insurance plans when Provider has knowledge that a patient is a Beneficiary receiving Inpatient Psychiatric Services under this agreement is also a Beneficiary of the Federal Medicare program or a private health insurance plan. In the event Provider collects monies from one of the foregoing entities, Provider shall notify County and County's compensation obligations under this agreement shall be reduced by the amount actually collected by Provider. No adjustment shall be made for any amounts that Provider is unable to collect.

B. **Billing Procedures**.

Provider shall submit claims to the Fiscal Intermediary for all services rendered under the terms of this agreement in accordance with the applicable billing requirements contained in section 5778 of the Welfare and Institutions Code and the regulations adopted pursuant thereto.

C. **Day of Service**.

A Day of Service shall be billed for each Beneficiary who meets admission and/or continued stay criteria, documentation requirements, treatment and discharge planning requirements, and occupies a psychiatric inpatient hospital bed at 12:00 midnight in the Facility of either Provider or the facilities of an authorized appropriately licensed Provider subcontractor.

D. **Reimbursement**.

1. Reimbursement shall be on a Fee-For-Service basis at an all-inclusive negotiated rate as stated in **EXHIBIT NO. 1** of this agreement. A Day of Service shall be billed for each Beneficiary who meets admission and/or continued stay criteria, documentation requirements, treatment and discharge planning requirements, and occupies a psychiatric inpatient hospital bed pursuant to Article IV.C. of this agreement. Professional fees are included in the daily rate.

2. During the term of this agreement, the Health and Human Services Agency ("HHSA") Director ("Director"), or any HHSA Branch Director designated by Director, may approve rate changes, both retroactive and prospective, provided that the increase in any single rate set forth in **EXHIBIT NO. 1** on the effective date of signing of this agreement shall not exceed 10 percent over the original rate per fiscal year, during the entire term of this agreement provided further that any rate increase shall not increase the total compensation payable under this agreement.

E. **Reimbursement Definition as Applied to this Agreement**.

1. Administrative Days.

There will be reimbursement for those days authorized by Provider or Provider's Utilization Review Committee in an acute inpatient facility when, due to the lack of Medi-Cal-eligible nursing facility, the Beneficiary's stay at an acute inpatient facility must be continued beyond the Beneficiary's need for acute care. Provider is responsible for collaborating with County TAD office to contact appropriate facilities within a 60-mile radius at least once each five working days until the Beneficiary is placed or no longer requires that level of care. These contacts must be documented by Provider and County and include a brief description of status and the signature of the person making the contacts. The Physician Reviewer or a Utilization Review Committee must monitor the Beneficiary's chart on a weekly basis to determine if the Beneficiary's status has changed or that no facility exists within a 60-mile radius. After written approval of County, at least

one facility can be contacted weekly to meet the foregoing requirement of contracting appropriate facilities within a 60-mile radius when it is determined by County that this finding has been documented in the Beneficiary's chart.

F. **Rate Exclusion**.

The rate structure in **EXHIBIT NO. 1** of this agreement is intended by both County and Provider to be inclusive of all services defined and provided pursuant to this agreement.

ARTICLE V
INDEMNIFICATION & INSURANCE

A. **Indemnification and Insurance**.

1. **Hold Harmless**.

It is agreed by the Parties to this agreement, Provider and County, that each will mutually indemnify, defend and hold the other Party and its appointed and elected officials, officers, volunteers, agents, and employees harmless from all costs, expenses, losses and damages, including death, personal injuries and damages to property caused or contributed to by any act or neglect of such Party, its appointed or elected officials, officers, volunteers, agents, or employees in the performance of this agreement.

2. **Insurance Requirements**.

a. Without limiting Provider's duties of defense and indemnification, Provider shall obtain, from an insurance carrier authorized to transact business in the State of California or maintain programs of self-insurance approved by County's Risk Manager, and maintain continuously during the term of this agreement, Commercial General Liability Insurance, including coverage for owned and non-owned automobiles, with limits of liability of not less than $1 million per occurrence and $3 million aggregate bodily injury and property damage; such insurance shall be primary as to any other insurance maintained by County for the acts of Provider and its employees.

b. Provider and any subcontractor shall obtain and maintain continuously Workers' Compensation and Employer's Liability Insurance to cover Provider and Provider'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 Provider or maintain programs of self-insurance therefore and as approved by County's Risk Manager. Each such policy shall be endorsed to state that the Workers' Compensation carrier waives its right of subrogation against the County, its elected officials, officers, employees, agents, and volunteers which might arise in connection with this agreement. Provider hereby certifies that Provider 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 Provider shall comply with such provisions before commencing the performance of the work or the provision of services pursuant to this agreement.

c. Provider shall obtain and maintain continuously a policy of Errors and Omissions coverage with limits of liability of not less than the $1 million per occurrence and $3 million annual aggregate.

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

(1) Any deductible or self-insured retention exceeding $25,000 for Provider or subcontractor shall be disclosed to and be subject to approval by County's 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, Provider 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, Provider 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 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) 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) Provider shall provide County with a certificate of insurance as evidence of insurance protection before the effective date of this agreement.

(6) The insurance 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, Provider shall provide County, at least twenty (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 Provider 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 and pay in full all contractual invoices for work completed prior to expiration of insurance.

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

(8) Any of Provider’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.

ARTICLE VI
RECORDS, AUDITS, REPORTS, AND RECOVERY OF OVERPAYMENTS

A. **Inspection Rights**.

1. Provider, upon written request, shall make all of its books and records pertaining to the services furnished under the terms of this agreement available for inspection, examination, or copying:

   a. By County, agents of the State of California, and the United States Department of Health and Human Services.

   b. At all reasonable times at Provider's Facility or Provider's place(s) of business or at such other mutually-agreeable location(s) in California.

   c. In a form maintained in accordance with the general standards applicable to such books or records.

   d. For a term of at least seven years from the close of the County Fiscal Year in which this agreement was in last effect, or until resolution of any audit, review, claim, or litigation pursuant thereto, whichever is later. For the purposes of this agreement, the County Fiscal Year begins on July 1 and ends on June 30 of the following calendar year.

   e. By making adequate office space available for review teams or auditors to perform the inspection, examination, and/or copying described herein. Such space must be capable of being locked and secured to protect the work of the review team or auditors during the period of their inspection, examination, and/or copying.

   f. By permitting on-site reviews and audits during normal working hours with at least 72-hour notice, except that unannounced on-site reviews and requests for information may be made at the sole discretion of the inspecting entity in those exceptional situations where arrangement of an appointment beforehand is clearly not possible or clearly inappropriate to the nature of the intended review and/or audit.

2. These audits or reviews may evaluate the following matters pertinent to Medi-Cal beneficiaries:

   a. Level and quality of care, and the necessity and appropriateness of the services provided.

   b. Internal procedures for assuring efficiency, economy, and quality of care.

   c. Grievances or complaints relating to medical care and their disposition.

   d. Beneficiary-related financial records when determined necessary by County to assure accountability for public funds.

3. The Parties agree that the purpose of the audits and reviews authorized by Article VI.A. of this agreement is solely to assess Provider and Provider's subcontractor's compliance with the terms and conditions of this agreement.

4. Provider does not waive the provisions of Evidence Code section 1157 with regard to medical staff records as applicable to state and federal laws and Provider's Bylaws.

B. **Records to be Kept; Audits or Review; Availability; Period of Retention**.

1. Provider or such Parties thereof as may be engaged in the performance of this agreement and subject to the inspection, examination, and copying of the information specified in this Article (Article VI)

shall, upon 48 hours of advance notice and during customary business hours, be subject to inspection, examination, and copying by any duly authorized agents of County, the State of California Department of Health Care Services(or any other subsequent appropriate state agency), the United States Department of Health and Human Services, and the Comptroller General of the United States. The United States Department of Health and Human Services and Comptroller of the United States are intended third-party beneficiaries of this covenant.

2. Provider shall maintain complete financial records including an annual, independent audit prepared in accordance with OMB Circular A-133, which clearly reflects the actual cost of each type of service for which Provider claims payment hereunder. The Beneficiary-eligibility determination and the fees charged to and collected from Beneficiaries shall also be shown in such records, and any apportionment of costs shall be made in accordance with P.L. 98-502 (31 USC section 7501 et seq.), OMB A-133 and generally accepted accounting principles.

3. Provider shall maintain the above information in accordance with Medicare principles of reimbursement and consistent with the requirements of the State of California Health Facilities Commission. In cases where any of the above requirements are in conflict, Provider's compliance with any one of such requirements is sufficient.

4. Provider shall maintain medical records as required by sections 70747 through 70751 of Title 22 of the California Code of Regulations and other records related to a Beneficiary's eligibility for services, the service rendered, the Beneficiary to whom the service was rendered, the date of the service, the medical necessity of the service, and the quality of service provided. Records shall be maintained in accordance with section 51476 of Title 22 of the California Code of Regulations. The foregoing constitutes "records" for the purposes of this Article (Article VI).

C. **Subcontracts**.

Provider shall maintain and make available to County, the United States Department of Health and Human Services, and agents of the State of California, upon written request, copies of all subcontracts for the performance of any of Provider's obligations and responsibilities under this agreement. Provider shall assure that all subcontracts entered into from the effective date of this agreement shall require subcontractors to:

1. Make all applicable books and records pertaining to this agreement available upon 48 hours of advance notice and during customary business hours for inspection, examination, or copying by County, the State of California Department of Health Services, or the United States Department of Health and Human Services.

2. Retain such books and records for a term of seven years from the close of the State of California's fiscal year in which the subcontract became effective or until resolution of any audit, review, or claim, or litigation pursuant thereto, whichever is later.

D. **Recovery of Overpayments to Provider, Liability for Interest**.

1. When an audit or review performed by any authorized agency discloses that Provider has been overpaid under this agreement, or where the total payments exceed the total liability under this agreement, Provider covenants that any such overpayment or excess payments over liability may be recouped by County by withholding the amount due from future payments, seeking recovery by payment from Provider, or a combination of these two methods.

2. When recoupment or recovery is sought under Article VI.D.1. of this agreement, Provider may appeal according to applicable procedural requirements of the regulations adopted pursuant to Part 2.5 of Division 5 (commencing at section 5775) of the Welfare and Institutions Code with the following exceptions:

a. The process for recovery or recoupment shall commence within 60 days after issuance of account status or demand resulting from an audit or review and shall not be deferred or tolled by the filing of a request for an appeal according to the applicable regulations.

b. Provider's liability to County for any overpayment or excess payment shall be as provided in section 5779(e) of the Welfare and Institutions Code.

E. **Confidentiality of Beneficiary Information**.

Notwithstanding any other provision of this agreement, names of Beneficiaries receiving public social services hereunder are confidential and are to be protected from unauthorized disclosure in accordance with Chapter IV of Subchapter C of Part 431 of Subpart F of Title 42, of the Code of Federal Regulations (commencing at section 431.300) and section 14100.2 of the Welfare and Institutions Code and regulations adopted there under. For the purpose of this agreement, all information, records, date, and data elements collected and maintained under this agreement and pertaining to Beneficiaries shall be protected by Provider from unauthorized disclosure. This provision shall survive the termination, expiration, or cancellation of this agreement.

In addition, Provider shall comply with all other applicable state and federal requirements regarding confidentiality of patient information (including, but not limited to, section 5328 of the Welfare and Institutions Code; section 56.10 of the Civil Code; the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the privacy and security regulations adopted pursuant thereto; Title 42, Code of Federal Regulations, Part 2; and Title 45, Code of Federal Regulations, section 205.50). This provision shall survive the termination, expiration, or cancellation of this agreement.

F. **Protection of Confidentiality and Programs**.

Except when disclosure is required by law, regulation, or legal process, Provider agrees to ensure the confidentiality of all information obtained from County including, but not limited to, financial, utilization, or any other information related to the delivery of health care.

G. **Third-Party Liability**.

Provider shall report within one business day to County whenever Provider discovers that the costs of Inpatient Psychiatric Services provided under this agreement and rendered either directly by Provider or through the instrumentality of a Provider subcontractor are covered, in whole or in part, by workers' compensation, tort liability, or casualty insurance. Nothing contained herein shall be construed to reduce or modify County's obligation to reimburse Provider for Medi-Cal benefits rendered to a Beneficiary.

ARTICLE VII
PATIENTS' RIGHTS

A. **Patients' Rights**.

1. County shall provide Patients' Right Advocate to provide the services outlined in Welfare and Institutions Code Section 5520.

2. Provider shall maintain a policy that specifies the qualifying criteria, including training criteria for LPS designated staff that includes Patients' Rights training and Welfare and Institutions Code Section 5150 training. The facility LPS designated staff must maintain designated status under the County of Shasta by attending and successfully completing Patient's Rights and Welfare and Institutions Code Section 5150 training every 12 months. The time, date and location of each training provided by the Provider shall be set by the Provider.

3. County may provide Patients' Rights training and Welfare and Institutions Code Section 5150 training to Provider's designated staff at the request of Provider. In the event County provides the training, the time, date and location of each training shall be set by County.

4. Provider shall comply with all applicable laws and regulations pertaining to the rights of Beneficiaries and patients. Specifically, Provider shall adopt and post in a conspicuous place or places a written policy on the rights of patients in accordance with section 70707 of Title 22 of the California Code of Regulations and shall comply with sections 5325 and 5325.1 of the Welfare and Institutions Code. Alleged or suspected violations of patient rights as set forth in sections 5325 and 5325.1 shall be investigated by the local director of mental health, or his/her designee pursuant to section 5326.9, and complaints by Beneficiaries shall be investigated by County's Patients' Rights Advocate pursuant to sections 5500 – 5550,, and, when appropriate, by the State of California Department of Health Care Services (or any other subsequent appropriate state agency) or other persons and entities as required by law or regulation.

5. Comply with County findings as a result of any County investigation pursuant to WIC section 5326.90.

B. **Notification of Rights.**

At the time of a Beneficiary's admission to Provider's Facility, the Beneficiary shall be notified in writing of their rights in accordance with section 70707 of Title 22 of the California Code of Regulations and with sections 5325 and 5325.1 of the Welfare and Institutions Code. The Beneficiary's signed and dated copy of the notification shall be kept in the Beneficiary's case record, a copy of which shall be made available to the client.

ARTICLE VIII
TERMS, TERMINATION, AND EFFECT OF TERMINATION

A. **Term**.

The term of this agreement shall commence as of the date it is last signed by all Parties and shall end June 30, 2021. Notwithstanding the foregoing, County shall not be obligated for payments hereunder for any future County fiscal year unless or until County's Board of Supervisors appropriates funds for this agreement in County's budget for that County Fiscal Year. In the event that funds are not appropriated for this agreement, then this agreement shall end as of June 30 of the last County Fiscal Year for which funds were appropriated. For the purposes of this agreement, the County fiscal year commences on July 1 and ends on June 30 of the following year. County shall notify Provider in writing of such non-appropriation at the earliest possible date.

B. **Termination for Cause**.

If Provider materially fails to perform Provider's responsibilities under this agreement to the satisfaction of County, or if Contractor fails to fulfill in a timely and professional manner Provider's responsibilities under this agreement, or if Provider 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 Contractor. If termination for cause is given by County to Provider and it is later determined that Provider 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 Section C of this Article VIII.

C. **Termination Without Cause**.

Provider and/or County may terminate this agreement upon providing the other Party with 30 days prior written notice. In any case, where such notice is provided, both Parties shall negotiate in good faith during such 30-day period in an effort to develop a revised agreement, which to the extent reasonably practical, under the circumstances, will adequately protect the interests of both Parties.

D. **Termination Based on Unforeseen Events**.

In the event that changes are made in County's agreement with the State of California for the provision of mental health services, Provider and County may terminate this agreement immediately by giving oral notice to the other Party based on the following unforeseen events:

1. Changes are made in the Medi-Cal program, or changes are made in federal laws or regulations governing the Medi-Cal program;
2. Changes are made in the Federal Medicare program;
3. Changes are made under other public or private health and/or Provider insurance programs, or policies, which have a material detrimental financial effect on the operations of Provider and/or County.

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

E. **Notice to State**.

If Provider terminates this agreement, County shall send a copy of the notice of termination to the State of California Department of Health Services.

F. **Obligations After Termination**.

In the event that this agreement is terminated, County may transfer individuals being treated under the terms of this agreement to another provider. If County is not able to transfer all affected individuals to another

provider by the termination date, at County's request, Provider shall continue to provide Inpatient Psychiatric Services in accordance with the terms of this agreement to such individuals who have not been transferred, until those individuals have been transferred to another provider. Provider shall assist and cooperate with County during the transfer and shall provide all necessary information to ensure continuing care. Following the effective date of termination of this agreement, the provisions of this agreement shall be of no further force and effect except that:

1. Each Party shall remain liable for any obligations or liabilities arising from activities carried on by each Party prior to the effective date of termination.

2. The provisions relating to insurance; indemnification; maintenance of and access to books, documents, and records following termination; continuation of services following termination; compliance with the law; and other related provisions of this agreement; as well as non-disclosure, confidentiality, and non-disparagement provisions thereof shall survive the expiration, termination, or cancellation of this agreement.

G. **Right to Terminate**

County's right to terminate this agreement may be exercised by County's Board of Supervisors, County's Executive Officer, or the HHSA Director or any HHSA Branch Director designated by the HHSA Director.

ARTICLE IX
APPLICABILITY OF STATUTES

A. **Application of Statutes**.

1. This agreement shall be governed and construed in accordance with the laws of the State of California and the United States, including, but are not necessarily limited to, the following:

   a. Title XIX of the Social Security Act and regulations promulgated thereunder. (42 USC section 1396 et. seq.)

   b. The California Welfare and Institutions Code and related provisions thereunder.

   c. Titles 17 and 22 of the California Code of Regulations.

2. All references in this agreement to any law or regulation, state or federal, which may from time to time be changed by appropriate authority during the term of this agreement, are binding upon the Provider and County.

B. **Severability**.

1. In the event any provision of this agreement is rendered invalid or unenforceable by Act of Congress, by statute of the State of California, and by any regulation duly promulgated by the United States or the State of California in accordance with law, or is declared null and void by any court of competent jurisdiction, the remainder of the provisions hereof shall remain in full force and effect.

2. If there is determination that any of the provisions of this agreement are invalid or unenforceable or declared null and void or which materially alters the obligations of either Party in such manner as to cause financial hardship to such Party, the Party so affected shall have the right to terminate this agreement upon providing 30 days prior written notice to the other Party.

ARTICLE X
GRIEVANCES AND APPEALS

A. **Contract Administrator**.

The Director, or HHSA Branch Director, as designated by the Director, is hereby designated the Contract Administrator of this agreement. The Contract Administrator shall be the initial authority for presentation and resolution of disputes arising under this agreement.

B. **Hospital Grievance Procedures**.

Provider shall have in place its own internal grievance policies and procedures, a copy of which shall, upon request, be made available to County.

C. **Principles of Informal Resolution of Grievances**.

Each Party shall designate a liaison, pursuant to Article II.I., who shall act as the initial contact point for resolution of any dispute concerning the terms of this agreement or any services or activities carried on under its terms. County and Provider shall make every reasonable effort to resolve all disputes and differences informally. In the event of such dispute or difference, County and Provider shall initiate telephone or written contact with the respective designated liaisons.

D. **Designee for Beneficiary Grievances**.

For Beneficiary grievances, County's designee shall be the County's Patients' Rights staff.

E. **Formal Resolution of Beneficiary Grievances**.

The Beneficiary, or his/her representative, may initiate a formal grievance by filing a written or oral grievance with the Shasta County Managed Care Program. To file a written grievance the Beneficiary shall complete and submit the Shasta County Grievance Brochure, **EXHIBIT NO. 3**, attached and incorporated herein, to Shasta County Managed Care Program, 2640 Breslauer Way, Redding, CA 96001. The Patient's Rights Advocate may assist the Beneficiary to complete and submit the written form, if requested by the Beneficiary. Oral grievances may be filed by contacting the Shasta County Managed Care Program at (530) 245-6750. Confidentiality of the Beneficiary shall be protected at all stages of the grievance process.

F. **Provider Appeal Procedures**.

If an informal resolution does not resolve a dispute concerning the terms of this agreement, Provider will cooperate with formal grievance procedures developed by County and approved by the California Department of Health Care Services (or any other subsequent appropriate state agency) as described in **EXHIBIT NO. 2**, attached and incorporated herein.

ARTICLE XI
HIPAA

The Parties acknowledge the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations ("HIPAA"). Provider understands and agrees that, as a provider of medical treatment services, it is a "covered entity" under HIPAA and, as such, has obligations with respect to the confidentiality, privacy, and security of patients' medical information, and must take certain steps to preserve the confidentiality of this information, both internally and externally, including the training of staff and the establishment of proper procedures for the release of such information. The Parties acknowledge their separate and independent obligations with respect to HIPAA, and that such obligations relate to transactions and code sets, privacy, and security. Provider understands and agrees that it is independently responsible for compliance with HIPAA and agrees to take all necessary and reasonable actions to comply with the requirements of HIPAA related to transactions and code sets, privacy, and security. The Parties agree that, should either Provider or County fail to comply with its obligations under HIPAA, it shall indemnify and hold harmless the other party (including its officers, employees, and agents), for damages attributable to such failure. The indemnification provided in this section is in addition to, and does not in any way limit, the hold harmless, indemnification, and defense obligations of the Parties that are provided for in Article V.

ARTICLE XII
MISCELLANEOUS

A. **Time is of the Essence**.

Time shall be of the essence for each and every term, obligation, and condition of this agreement.

B. **Entire Agreement**.

This agreement, together with all EXHIBITS hereto, contains the entire agreement between the Parties relating to the rights herein granted and the obligations herein assumed. It is the express intention of Provider and County that any and all prior or contemporaneous agreements, promises, negotiations, or representations either oral or written relating to the subject matter and period governed by this agreement which are not expressly set forth herein shall be of no further force, effect, or legal consequence after the effective date hereof.

C. **Amendments**.

No changes, amendments or alterations to this agreement shall be effective unless in writing and signed by both Parties. In addition to the provisions of Article IV D.2 of this agreement, 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 Provider and the County's HHSA Director, or any HHSA Branch Director designated by the HHSA Director, 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).

D. **Headings**.

The headings or titles of articles and sections contained in this agreement are intended solely for the purpose of facilitating reference, are not a part of this agreement, and shall not affect the meaning or interpretation of this agreement.

E. **Independent Contractors**.

This agreement does not constitute a hiring by either Party. It is the Parties' intention that, to the full extent permitted by law, Provider shall be an independent contractor and not an employee of County nor the Shasta County Health and Human Services Agency, and in conformity therewith, that Provider shall retain sole and absolute discretion and judgment in the manner and means of carrying out Provider's activities and obligations under this agreement. Therefore, the Parties hereto are and shall remain independent contractors bound by the provisions hereof. Provider is responsible and obligated to County as to the results accomplished. Except as provided by law, County thereby obtains no authority or right to direct or control Provider's actions, and Provider assumes and retains discretion for methods, techniques, and procedures in management. Further, Provider acknowledges that neither it nor its employees are entitled to participate in any Workers' Compensation benefits, pension plan, retirement plan, bonus, or any similar benefits, which are provided by County as a condition of employment by County.

F. **Federal Healthcare Compliance Program.**

1. In entering into this agreement, Provider attests they have an active Program for Compliance with Federal Healthcare Programs in place and provide regular training on Federal Healthcare Compliance to all staff who provide services that are paid for with Federal Healthcare dollars. Provider further acknowledges the County's Program for Compliance with Federal Healthcare Programs and the Contractor Code of Conduct (Code of Conduct), attached and incorporated herein as **EXHIBIT NO. 5.** Should the aforementioned Code of Conduct be amended during the term of the agreement, Provider shall comply with the Code of Conduct as amended and provided to Provider by County.

2. Provider shall not enter into an agreement to provide of services pursuant to the provisions of this agreement with any provider who is, or at any time has been, excluded from participation in any federally funded healthcare program, including, without limitation, Medi-Care or Medi-Cal.

3. Provider attests that Provider and all Provider's employees and subcontractors who are providing services pursuant to the provisions of this agreement are not excluded from Medi-Cal and Medicaid provider participation.

G. **No Inducement to Refer**.

Nothing contained in this agreement shall require County to refer any patients to Provider for treatment. The Parties enter into this agreement with the intent of conducting their relationship in full compliance with all applicable federal, state, and local law, including the Medicare/Medicaid Anti-Fraud and Abuse Amendments. Notwithstanding an unanticipated effect of the provisions herein, neither Party will intentionally conduct itself under the terms of this agreement in a manner to constitute a violation of federal, state, and local law, including the Medicare/Medicaid Anti-Fraud and Abuse Amendments.

H. **Meetings.**

1. Provider will attend quarterly meetings with local area hospitals, local law enforcement and County to discuss issues of inpatient hospitalization and related procedural concerns.

2. Provider will provide at least one representative to attend County's bi-annual Designated Facilities meeting.

I. Provider shall comply with WIC sections 8100 – 8108 regarding notification to the California Department of Justice.

ARTICLE XIII
NOTICES

A. Except as may otherwise be specifically provided in this agreement with respect to oral notice, 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.

County:	Director of Adult Services ATTN: Contracts Unit P.O. Box 496005 Redding, CA 96049-6005 Phone: (530) 225-5900 Fax: (530) 225-5977
Provider:	Chief Executive Officer Shasta Regional Medical Center 1100 Butte St. Redding, CA 96001 Phone: Fax:

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

EXHIBIT NO. 1
REIMBURSEMENT ADDENDUM

A. **Provider Inpatient Service Reimbursement**.

1. County shall pay Provider 100 percent of the following all-inclusive rates per day for admissions:

Medi-Cal Inpatient Acute (Adult/Older Adult)	$1,000.00 per day
Medi-Cal Inpatient Administrative Day*	$ 565.58 per day
Medi-Cal Inpatient Professional Fees	$ 100.00 per day
Short Doyle Inpatient Acute (Adult/Older Adult), All inclusive	$1,100.00 per day
Short Doyle, Inpatient Administrative	$ 565.58 per day

**Administrative day rates reflect the state established rate per the most recent DHCS Notice as of the date agreement is signed and is subject to change per written notification from DHCS.*

2. The all-inclusive per diem rates, as described above, are to be the only payments made by County for Inpatient Psychiatric Services provided to Medi-Cal Beneficiaries under this agreement except where otherwise provided hereunder.

3. The rate structure under Section A.1 of this EXHIBIT shall not include transportation services required in providing Inpatient Psychiatric Services under this agreement. When transportation services are Medi-Cal eligible services, they shall be billed separately from the per diem rate for the Inpatient Psychiatric Services provided under this agreement.

The total compensation payable under this agreement shall not exceed $7,500,000 during the entire term of the agreement and shall not exceed $2,500,000 during any County Fiscal Year, July 1 – June 30.

COVERED/NON-COVERED SERVICES

The following services listed under "Covered Services" are included in the per diem rates, while services listed under "Non-Covered" Services are excluded from the per diem rates.

INCLUDED SERVICES

Clinical Laboratory Services
Dietary Services and Consultations
Drug Screening
Educational Services
Emergency Services
Family Therapy
Group Therapy
Involuntary Patient Care
Medical History and Physical Examination
Pharmacy Services
Psychiatric Nursing Services
Recreation Services
Seclusion Room w/Special Observation
Social Services
Urinalysis
Medical History
Physical Examination (Tech component)

NON-COVERED SERVICES

Ambulance Services
Arteriogram
Biofeedback
Brain Mapping
CAT Scans
Chest X-ray
Electrocardiography
Electroconvulsive Therapy (ECT)
Electroencephalography
Inhalation Therapy
MRI
Physician Services
Psychological Testing
Speech and Language Services

Both the Short-Doyle/Medi-Cal Maximum Allowance rate and the Federal Financial Participation are adjusted during the year. The rates noted in this agreement are subject to change, and Provider shall be paid at the adjusted interim rates up to the agreement's maximum amount, without amendment to this agreement.

EXHIBIT NO. 2
PROVIDER APPEAL PROCEDURE

A. Every effort shall be made to process claims in a timely manner and resolve disagreements informally as outlined prescribed in Article X. of this agreement. In the event disagreements cannot be resolved informally, the following Provider appeal procedures are to be followed.

1. Provider may file a written appeal concerning the processing or payment of its claims for Inpatient Psychiatric Services provided pursuant to this agreement directly to the Fiscal Intermediary. The written appeal shall provide all facts and documents to support the Provider's appeal and that appeal shall clearly state the grounds for the appeal. The Fiscal Intermediary will have 60 days from receipt of the appeal to review the claim, seek information, and respond in writing to Provider.

2. Provider may appeal a denied request for reimbursement of Inpatient Psychiatric Services provided pursuant to this agreement to County. The written appeal must be received by the Contract Administrator within 90 calendar days of the date of notification of the non-approval of payment. Appeals shall be in writing and include all relevant documentation.

   a. County shall have 60 calendar days from the receipt of the appeal to inform the Provider in writing of the decision and its basis.

   b. If no basis is found for altering the decision or the remedy is not within the purview of County, Provider will be notified of its right to submit the appeal to the State of California Department of Health Care Services (or any other subsequent appropriate state agency).

   c. If County upholds Provider's appeal, County has 15 days from the date the Provider was notified in writing of the decision to submit an approved payment authorization document or take corrective action.

3. If County does not respond within 60 days, Provider has the right to appeal directly to the State of California Department of Health Care Services (or any other subsequent appropriate state agency).

4. If Provider wishes to appeal to the State of California Department of Health Care Services (or any other subsequent appropriate state agency), Provider must do so within 30 calendar days from the date of County's written decision or within 30 calendar days from expiration of the time within which the County is required to respond to an appeal, should County fail to respond.

5. The State of California Department of Health Care Services (or any other subsequent appropriate state agency) will have 60 calendar days from the receipt of the appeal to notify in writing Provider and County of its decision and the basis for the decision. If the State of California Department of Health Care Services (or any other subsequent appropriate state agency) does not respond within 60 calendar days from the receipt of the appeal, the appeal is deemed denied.

6. If the State of California Department of Health Care Services (or any other subsequent appropriate state agency) upholds Provider's appeal, County has 15 days from receipt of the State Department of Health Care Services' written decision to submit an approved payment authorization document or take corrective action.

EXHIBIT NO. 3
NOTIFICATION OF RIGHTS FORM

Beneficiary's Name: _____ Date: _____ Time: _____

I understand that as a Beneficiary of SHASTA COUNTY's Inpatient Mental Health Plan, I have the right to access both Provider's and SHASTA COUNTY's Complaint Resolution and Grievance Process.

If I am not satisfied with Provider's service, I will first attempt to obtain a resolution through the Provider's Complaint Resolution and Grievance Process.

If a satisfactory resolution cannot be obtained through Provider, I have the right to access another level of appeal through the Mental Health Plan's Complaint Resolution and Grievance Process by contacting the Patient's Rights Advocate at (530) 225-5506.

I have the right to use Provider's or the Mental Health Plan's Complaint Resolution and Grievance Process at any time before, during, or after the Complaint Resolution and Grievance Process has begun.

I may obtain a full description of the Mental Health Plan and/or Provider's Complaint Resolution and Grievance Process upon request.

When appropriate,

_____ _____

Beneficiary Signature* **Date** **Parent/Guardian/Conservator Signature** **Date**

_____

Provider Center Staff Signature **Date**

When appropriate, reason Beneficiary is unwilling to sign: _____

_____

_____

_____

_____

_____

***If the Beneficiary is unable to understand and sign the Notification of Rights Form by reason of his/her mental disorder, Provider Staff will continue to request the Beneficiary's signature throughout hospitalization.**

Original: Beneficiary Case Record

EXHIBIT NO. 4
GRIEVANCE BROCHURE

SHASTA COUNTY HEALTH AND HUMAN SERVICES AGENCY
2640 Breslauer Way
Redding, CA 96001
www.shastahhsa.net

Health and Human Services Agency

Shasta County Health & Human Services Agency
Attn: Managed Care & Compliance HHB-502
P.O. Box 496005
Redding, CA 96049-6005

WHAT HAPPENS TO YOUR GRIEVANCE?

To make sure your complaint is taken care of, we will:

- Send you a letter to say we got it.
- Choose someone that is not part of your complaint to look over your grievance.
- Send you a letter to tell you what was decided.

You will be treated fairly during this process.

For questions, or the status of your grievance, call Managed Care at 530-245-6750 or toll free at 1-888-385-5201.

Our ADA coordinator may be reached at:

530-225-5515 (phone)

530-225-5345 (fax)

California Relay Service: 711

Health and Human Services Agency

2640 Breslauer Way
Redding, CA 96001
www.shastahhsa.net

Revised 08/17

Grievance Form

Let us help you resolve any service complaints.

For help call:
(530) 245-6750

WHY FILE A GRIEVANCE?

Shasta County tries to work fairly with everyone but sometimes things do not work out. You can file a grievance if you are not happy with your services.

HOW TO FILE A GRIEVANCE

Fill out this form or tell us. To tell us, call (530) 245-6750 or 1-888-385-5201. If you fill out the form, send it to the address on the back or give it to your health care worker.

GRIEVANCE FORM

You may ask for help filling out this form or have someone do it for you.

You will be treated fairly if you file this form.

Date:_____ **Location:**_____

Name:_____ **Birth Date:**_____

Address:_____ **City:**_____ **State:**_____

Telephone: (home)_____ **(work)**_____ **(cell)**_____

Primary Language Spoken: _____

Describe the reason for your dissatisfaction: _____

_____

_____

_____

How do you think this can be resolved? _____

_____

_____

_____

Signature: _____

EXHIBIT NO. 5

SHASTA COUNTY HEALTH AND HUMAN SERVICES AGENCY, MENTAL HEALTH PLAN (MHP) CONTRACTOR CODE OF CONDUCT

Shasta County Health and Human Services Agency (HHSA), maintains high ethical standards and is committed to complying with all applicable statutes, regulations, and guidelines. HHSA Contractors shall follow this Contractor Code of Conduct (Code of Conduct) as applicable to services performed under the Managed Care Plan agreement between Shasta County and the State Department of Health Care Services and this Agreement between the County of Shasta and Contractor.

1. PURPOSE

The purpose of this HHSA Code of Conduct is to ensure that all HHSA Contractors providing services under the Shasta County Managed Care Plan (the agreement between Shasta County and State of California Department of Health Care Services to provide specialty mental health services to eligible Shasta County Medi-Cal beneficiaries) and this Agreement between the County of Shasta and Contractor, are committed to conducting their activities ethically and in compliance with all applicable state and federal statutes, regulations, and guidelines applicable to Federal Health Care programs. This Code of Conduct also serves to demonstrate HHSA's dedication to providing quality care to its clients, and to submitting accurate claims for reimbursement to all payers.

2. CODE OF CONDUCT - GENERAL STATEMENT

A. This Code of Conduct is intended to provide HHSA Contractors with general guidelines, to enable them to conduct the business of HHSA in an ethical and legal manner;

B. Every HHSA Contractor is expected to uphold this Code of Conduct;

C. Failure to comply with this Code of Conduct, or failure to report reasonably suspected issues of non-compliance, may result in the HHSA Contractor's termination of contracted status. In addition, such conduct may place the Contractor, the individuals employed by Contractor, or HHSA, at substantial risk in terms of its relationship with various payers. In extreme cases, there is also the risk of action by a governmental entity up to and including an investigation, criminal prosecution, and/or exclusion from participation in the Federal Health Care Programs.

3. CODE OF CONDUCT

All HHSA Contractors and employees of Contractor shall:

A. Perform their duties in good faith and to the best of their ability;

B. Comply with all statutes, regulations, and guidelines applicable to Federal Health Care programs, and with this Code of Conduct;

C. Refrain from any illegal conduct. When a Contractor is uncertain of the meaning or application of a statute, regulation, or policy, or the legality of a certain practice or activity, Contractor shall inform the HHSA Compliance Officer or designee;

D. Not obtain any improper personal benefit by virtue of their contractual relationship with HHSA;

E. Notify the HHSA Compliance Officer or designee immediately upon the receipt, at any location, of any inquiry, subpoena, or other agency or government request for information regarding HHSA or the services provided under this agreement between HHSA and Contractor;

F. Not destroy or alter HHSA information or documents in anticipation of, or in response to, a request for documents by any applicable government agency or from a court of competent jurisdiction;

G. Not engage in any practice intended to unlawfully obtain favorable treatment or business from any entity, physician, client, resident, vendor, or any other person or entity in a position to provide such treatment or business;

H. Not accept any gift of more than nominal value or any hospitality or entertainment, which because of its source or value, might influence the Contractor's independent judgment in transactions involving HHSA or the services provided under this agreement between HHSA and Contractor;

I. Disclose to the HHSA Compliance Officer or designee any financial interest, official position, ownership interest, or any other financial or business relationship that they (or a member of their immediate family, or persons in their employ) has with HHSA's employees, vendors or contractors;

J. Not participate in any false billing of HHSA, client, other government entities, or any other party;

K. Not participate in preparation or submission of any false cost report or other type of report submitted to the HHSA or any other government entity;

L. Not pay, or arrange for Contractor to pay, any person or entity for the referral of HHSA client to Contractor, and shall not accept any payment or arrange for any other entity to accept any payment for referrals from Contractor;

M. Not use confidential HHSA information for their own personal benefit or for the benefit of any other person or entity, while under contract to HHSA, or at any time thereafter;

N. Not disclose confidential medical information pertaining to HHSA's clients without the express written consent of the client or pursuant to court order and in accordance with all applicable laws;

O. Promptly report to the HHSA Compliance Officer or designee any and all violations or reasonably suspected violations of this Code of Conduct;

P. Promptly report to the HHSA Compliance Officer or designee any and all violations or reasonably suspected violations of any statute, regulation, or

guideline applicable to Federal Health Care programs;

Q. Know they have the right to use HHSA's Confidential Disclosure Line without fear of retaliation with respect to disclosures; and with HHSA's commitment to maintain confidentiality, as appropriate; and

R. Not engage in or tolerate retaliation against anyone who reports suspected wrongdoing.

4. SHASTA COUNTY COMPLIANCE OFFICER

The Shasta County HHSA Compliance Officer may be contacted at:

Compliance Officer
Shasta County Health and Human Services Agency, Business & Support Services 1810 Market Street, Redding, CA 96001
P.O. Box 496005, Redding, CA 96049-6005 (530) 245-6750
24/7 Confidential Disclosure Line: (530) 229-8050 or 1-866-229-8050 Website Address:
http://www.co.shasta.ca.us/html/Mental_Health/About%20Us/About%20Us.htm
Email: mhcompofcr@co.shasta.ca.us

CODE OF CONDUCT CERTIFICATION PAGE FOLLOWS

Shasta County Health & Human Services Agency (HHSA)

CODE OF CONDUCT - CONTRACTOR C E R T I F I C A T I O N

I,_____, by signing this Certification
(Print First and Last Name)

acknowledge that:

1. I am an employee of Prime Healthcare Services - Shasta, LLC, a contractor of the County or Shasta, through its Health and Human Services Agency;

2. I have received a copy of the Code of Conduct;

3. I have read and understand the Code of Conduct; and

4. I agree to comply with the Code of Conduct.

Signed _____ Date _____

Contractor shall maintain all current signed Code of Conduct – Contractor Certification forms on file and retain forms for a period of seven years after employee no longer works for Contractor, and provide to HHSA upon request, or submit-depending upon agreement terms, this signed certification to HHSA Compliance Program staff at 1810 Market Street, Redding, CA 96001, or to P.O. Box 496005, Redding, CA 96049-6005.

Thank you.

EXHIBIT NO. 6

QUARTERLY REPORT

COMPLETED FORMS MAY BE MAILED, EMAILED OR FAXED
Shasta County Health and Human Services Agency
Adult Services Branch
ATTN: Contracts
2460 Breslauer Way, Redding CA 96001
Email: ASContracts@co.shasta.ca.us
FAX Number: (530) 229-8322

Provider Name: _____ Quarter Covered by Report: _____

Report Completed by: _____ Phone Number: _____

Email Address: _____ Date of Report: _____

1. Please report the following information for the quarter:

	0-17	18-20	21+
Total number of clients served			
Total number of unduplicated clients			
Total number of dual diagnosed clients			
Number of clients who received a diagnosis of Substance Use Disorder (SUD)			
Total number of unduplicated dual diagnosed clients			
Total number of rehabilitation services delivered			
Total number of group services delivered			
Total number discharged from care			

2. Please report the number of services delivered by each of the following classifications during the quarter:

	0-17	18-20	21+
Licensed Physician			
Licensed Psychologist			
Licensed Therapist			
Registered Nurse (RN)			
Licensed Vocational Nurse (LVN)			
Mental Health Technician (MHT)			

3. Please discuss outreach and/or collaboration with families, other agencies and community-based organizations.

4. Please report on any leadership and staff changes. List staff training provided and number of staff in attendance.

5. Please report any achieved outcome objectives and upcoming plans.

6. Please explain any contract related activities or unusual events.

7. Please describe any issues or problems encountered and the steps that have been taken to resolve these issues.

8. Progress on completing the additional requirements this quarter (Check if complete).

   ☐ All staff have been trained in and are adhering to the Code of Conduct.

   ☐ Patients have received information on their individual rights, program rules and regulations, and EPSDT.

   ☐ All staff working in program have passed the Sanction Checks.

9. Verification of your staff's absence from Federal Funding Exclusion List:

   By: _____ On: _____

10. If any of the additional requirements (question 8) have not been met, please provide explanation and a plan for meeting them:

11. Please report the number of Aftercare Services delivered in combination with Shasta County Adult Services throughout this quarter.

12. Please provide any other information you would like us to have.