STATE OF CALIFORNIA – DEPARTMENT OF GENERAL SERVICES

SCO ID: 4260-MS222317-A1

STANDARD AGREEMENT - AMENDMENT

STD 213A (Rev. 4/2020)

☒ **CHECK HERE IF ADDITIONAL PAGES ARE ATTACHED** 34 **PAGES**

AGREEMENT NUMBER	AMENDMENT NUMBER	Purchasing Authority Number
MS-2223-17	1	

1. This Agreement is entered into between the Contracting Agency and the Contractor named below:

CONTRACTING AGENCY NAME
California Department of Aging

CONTRACTOR NAME
San Bernardino County Department of Aging & Adult Svcs

2. The term of this Agreement is:

START DATE
07/01/2022

THROUGH END DATE
06/30/2023

3. The maximum amount of this Agreement after this Amendment is:

$ 1,847,820 One million eight hundred forty-seven thousand eight hundred twenty and 00/100 dollars

4. The parties mutually agree to this amendment as follows. All actions noted below are by this reference made a part of the Agreement and incorporated herein:

A. Exhibit A, Scope of Work (20 pages), is revised and replaced in its entirety, attached hereto, and made part of the Agreement.

B. Exhibit B, Budget Detail and Payment Provisions (7 pages), is revised and replaced in its entirety, attached hereto, and made part of the Agreement.

C. Exhibit E, Additional Provisions (7 pages), is revised and replaced in its entirety, attached hereto, and made part of the Agreement.

All other terms and conditions shall remain the same.

IN WITNESS WHEREOF, THIS AGREEMENT HAS BEEN EXECUTED BY THE PARTIES HERETO.

CONTRACTOR

CONTRACTOR NAME (if other than an individual, state whether a corporation, partnership, etc.)
San Bernardino County Department of Aging & Adult Svcs

CONTRACTOR BUSINESS ADDRESS	CITY	STATE	ZIP
150 S. Lena Road	San Bernardino	CA	92415-0515

NAME OF PERSON SIGNING	TITLE
Dawn Rowe	Chair, Board of Supervisors
CONTRACTOR AUTHORIZED SIGNATURE	DATE SIGNED

STATE OF CALIFORNIA

CONTRACTING AGENCY NAME
California Department of Aging

CONTRACTING AGENCY ADDRESS	CITY	STATE	ZIP
2880 Gateway Oaks Drive, Suite 200	Sacramento	CA	95833

PRINTED NAME OF PERSON SIGNING	TITLE
Nate Gillen	Chief, Business Management Bureau
CONTRACTING AGENCY AUTHORIZED SIGNATURE	DATE SIGNED
CALIFORNIA DEPARTMENT OF GENERAL SERVICES APPROVAL	EXEMPTION (If Applicable) SCM, Volume 1, 4.04, A., (4)

ARTICLE II. MULTIPURPOSE SENIOR SERVICES PROGRAM (MSSP) OVERVIEW

The MSSP is a Medi-Cal Home and Community Based Services Waiver, Control Number CA.0141.R06.00 authorized pursuant to Section 1915(c) of Title XIX of the Social Security Act (HCBS Waiver). The primary objectives of the MSSP are to:

1. Avoid the premature placement of frail older persons in nursing facilities

2. Foster independent living in their communities

Pursuant to an Interagency Agreement between Department of Health Care Services (DHCS) and California Department of Aging (CDA), CDA contracts with local government entities and private nonprofit organizations for local administration of the MSSP throughout the State. The Contractor is responsible for arranging for and monitoring community services to the MSSP Waiver Participant population in the catchment area identified in Exhibit G of this Agreement. Individuals eligible for MSSP must be age sixty-five (65) or older; meet the eligibility criteria as a Medi-Cal recipient with an eligible Medi-Cal Aid Code for MSSP as described in the MSSP Medi-Cal Aid Codes, Article V of this Exhibit; be certifiable for placement in a nursing facility; live within a site's catchment area; be served within the program's cost limitations; and be deemed appropriate for care management services.

The Contractor uses a care management team to assess eligibility and need and provide for delivery of services. The Contractor is reimbursed for expenditures through a claims process operated by the State's Medi-Cal Fiscal Intermediary (see definition in Article VI of this Exhibit).

ARTICLE III. MSSP PROGRAM OPERATIONS

The Contractor shall be responsible for all care management obligations including processing Waiver Participant applications, determining eligibility, conducting assessments, developing care plans, case recording and documentation, and providing follow-up. The Contractor shall directly provide or arrange for the continuous availability and accessibility of all services identified in each Waiver Participant's care plan. The Contractor shall also ensure that the administrative integrity of the MSSP is maintained at all times. In order to maintain adequate administrative control, the Contractor shall incorporate the following components into the scope of operations:

A. Care Management Team

1. The Contractor shall maintain and have on file a written description and an organizational chart that outlines the structure of authority, responsibility, and accountability within the MSSP and the MSSP parent organization. The Contractor shall provide to its assigned CDA analyst a copy of the organization chart within thirty (30) days of the execution of this Agreement.

2. The Contractor shall employ a care management team, which consists of a social worker and a registered nurse, that meet the qualifications set forth in

ARTICLE III. MSSP PROGRAM OPERATIONS (Continued)

the Waiver. The care management team shall determine Waiver Participant eligibility based on the criteria specified in the MSSP Site Manual, herein incorporated by reference. This team shall work with the Waiver Participant throughout the care management process (e.g., assessment, care plan development, service coordination, and service delivery).

3. The care management team shall: 1) provide information, education, counseling, and advocacy to the Waiver Participant and family, and 2) identify resources to help assure the timely, effective, and efficient mobilization and allocation of all services, regardless of the source, to meet the Waiver Participant's care plan goals.

4. The Contractor shall annually self-certify that staff meet the requirements as outlined in the MSSP Site Manual as well as participate in required trainings.

B. Care Plan

1. The Contractor's Care Management Team shall perform the MSSP Waiver Participant's assessments and work with the MSSP Waiver Participant, family, managed care plans, and others to develop a care plan covering the full range of required psycho-social and health services. The Care Management Team shall continue to work with the MSSP Waiver Participant to assure that the Waiver Participant is receiving and benefiting from the services and to determine if modification of the care plan is required.

2. Such MSSP subcontracts shall specify terms and conditions and payment amount and shall assure that subcontractors shall not seek additional or outstanding unpaid amounts from the MSSP Participant.

C. Purchased Waiver Services

"Purchased Waiver Services" means goods and services approved for purchase under Title XIX of the Social Security Act, 1915(c) Home and Community Based Waiver authority. The list of MSSP Purchased Waiver Services is included in Article VI. The Contractor may purchase MSSP Purchased Waiver Services when necessary to support the well-being of a MSSP Waiver Participant.

1. Prior to purchasing services, the Contractor shall verify, and document its efforts, that alternative resources are not available (e.g., family, friends and other community resources)

2. The Contractor may either enter into contracts with subcontractors to provide Purchased Waiver Services or directly purchase items through the use of a purchase order.

ARTICLE III. MSSP PROGRAM OPERATIONS (Continued)

3. The Contractor shall maintain written, signed and dated subcontracts for the following array of Purchased Waiver Services as defined in MSSP Site Manual at all times during the terms of this Agreement:

   a) Adult Day Care (ADC)
   b) Minor Home Repair/Maintenance Services
   c) Supplemental Homemaker, Personal Care and Protective Supervision Services
   d) Consultative Clinical Services
   e) Respite Care
   f) Transportation
   g) Meal Services
   h) Counseling and Therapeutic Services
   i) Communication Services

4. The Contractor shall assure that its subcontractors have the license(s), credentials, qualifications or experience to provide services to the MSSP Participant.

5. The Contractor shall be responsible for coordinating and tracking MSSP Purchased Waiver Services for a MSSP Waiver Participant.

6. The Contractor shall operate a Multipurpose Senior Services Program at a location and in a manner approved by the State, ensuring that Waiver Participant inquiries and requests for service(s) receive prompt response.

D. Case Files

The Contractor shall maintain an up-to-date, centralized, and secured case file record for each Waiver Participant, consisting, at a minimum, of the following documents prescribed by CDA:

1. Application for the MSSP

2. MSSP Authorization for Use and Disclosure of Protected Health Information

3. Participant Enrollment/Termination Information

4. Level of Care Certification "Level of Care" (LOC) means a clinical certification by the Contractor that a MSSP Applicant or MSSP Waiver Participant meets the requirement(s) for a nursing facility placement.

5. MSSP Initial Health Assessment, MSSP Initial Psychosocial Assessment, and MSSP Reassessments

ARTICLE III. MSSP PROGRAM OPERATIONS (Continued)

6. Care Plan and Service Planning and Utilization Summary (SPUS)

7. Waiver Participant monthly progress notes and other Waiver Participant-related information (e.g., correspondence, medical/psychological/social records, service delivery verification)

8. Denial or discontinuance letters (Notice of Action)

9. Termination documents

10. Fair Hearing documentation

E. Management Information Systems (MIS)

The Contractor shall maintain and operate an MIS at its site. The Contractor shall:

1. Maintain office space with proper security and climate control for on-site computer hardware, e.g., terminals, processors, modems, and printers.

2. Provide adequate staff for timely, accurate, and complete MIS data input, including but not limited to:

   a. Waiver Participant name, MSSP Waiver Participant number, Medi-Cal aid code, county code, Medicare and Social Security numbers, birth date, level of care, emergency contact information, physician information, and demographic information

   b. Tracking of Waiver Services and costs

   c. Enrollment and termination dates

   d. Provider Index Report

3. Accommodate State-required changes in MIS procedures which may be necessary from time to time.

4. Generate reports as required by the State.

5. Submit to CDA by the 5th working day of the month (unless otherwise specified by CDA), the active Waiver Participant count for the preceding month. The active Waiver Participant count consists of the number of Waiver Participants actively enrolled in MSSP on the last (business) day of the reporting month. This does not include Waiver Participant cases closed (or terminated) during the reporting month.

ARTICLE III. MSSP PROGRAM OPERATIONS (Continued)

6. Submit to CDA, by the 5th working day of the month (unless otherwise specified by CDA), the Wait List of Participants as of the last day of the previous month. "Wait List" means a list of potential MSSP Participants, established, and maintained by the Contractor, when the Contractor has reached its capacity. To ensure compliance with MSSP Waiver requirements and Centers for Medicare and Medicaid Services (CMS) direction, MSSP sites must develop and implement a wait list policy and procedure. The policy and procedure must include provisions for: prescreening individuals to determine eligibility; managing applicants' placement on and removal from the wait list; periodically reviewing the eligibility and identified needs of applicants on the wait list; and assigning priority for enrollment based on identified needs and level of risk. The Contractor determines the priority of enrollment into the MSSP in accordance with CDA and CMS requirements.

7. Verify all service data within ninety (90) calendar days of the date of service. The Contractor shall submit this data to CDA by the 5th calendar day of the following month, ninety-five (95) days from the end of the month of services.

8. Submit claims to the State's Medi-Cal Fiscal Intermediary (FI), per instructions stated in the Medi-Cal Provider Manual.

F. Enrollment Levels

The Contractor shall maintain a caseload of no less than 95 percent and no more than 105 percent of the specified number of participant slots for the term of contract (12 months) This is a performance requirement to ensure compliance with the terms and conditions of this Agreement and Waiver requirements. If the Contractor's active participant count falls below ninety-five percent (95%) of the number of budgeted participant slots for more than three (3) consecutive months, the Contractor shall be required to submit an enrollment plan for review, approval, and monitoring by CDA.

"Participant slot" means a position, whether vacant or filled, which is funded according to a Contractor's site budget and allocated for a participant during a given month.

G. Emergency Preparedness

1. The Contractor shall prepare and implement an emergency preparedness plan that ensures the provision of services to meet the emergency needs of Waiver Participants they are charged to serve during medical or natural disasters: a pandemic, earthquake, fire, flood, or public emergencies, such as riot, energy shortage, hazardous material spill, etc. This plan shall conform to any statewide requirements issued by any applicable State or local authority.

ARTICLE III. MSSP PROGRAM OPERATIONS (Continued)

2. The Contractor shall adopt policies and procedures that address emergency situations and ensure that there are safeguards in place to protect and support Waiver Participants in the event of natural disasters or other public emergencies.

3. The Contractor shall ensure that emergency preparedness policies and procedures are clearly communicated to site staff and subcontractors in order to provide care under emergency conditions and to provide for back-up in the event that usual care is unavailable.

4. The Contractor shall develop an emergency preparedness training plan to be provided to all staff at least annually and as needed when new staff are hired. The training shall consist of:

   a. Familiarity with telephone numbers of fire, police, and ambulance services for the geographic area served by the provider

   b. Techniques to obtain vital information from older individuals who require emergency assistance

   c. Written emergency procedures for all staff that have contact with older individuals

5. The Contractor shall develop a method for documenting the emergency preparedness training provided for all staff.

6. The Contractor shall develop a program for testing its emergency preparedness plan at least annually.

H. Other Provisions

1. The Contractor is relieved of all obligations to arrange for and provide services to a Waiver Participant under this Agreement after the Waiver Participant has been terminated from the MSSP and has exhausted their appeal rights.

2. The Contractor shall provide a notice of termination to a Waiver Participant prior to terminating the Participant from the MSSP and shall reference the MSSP Site Manual to determine how many days' notice are required based on the type of termination code that is used.

3. The Contractor shall administer a subcontractor appeal and adjudication process. The subcontractor appeal and adjudication process must be included in all subcontracts. This process shall assure fair consideration and disposition of subcontractor claims against the Contractor. Final authority to decide claims shall be vested with the Contractor. The subcontractor has no right of appeal to CDA.

ARTICLE III. MSSP PROGRAM OPERATIONS (Continued)

4. The Contractor shall serve participants in the Catchment Area as defined in Exhibit G of this Agreement.

5. The Contractor shall abide by the MSSP Site Manual, training manuals, and other guidance issued by the CDA MSSP Branch. The Contractor shall comply with any and all changes to State and federal law. The Contractor shall include this requirement in each of its subcontracts.

6. The Contractor shall make staff available to CDA for training and meetings which CDA may find necessary from time to time.

Contractors are to use the following codes to verify Waiver Participant eligibility. Multipurpose Senior Services Program Waiver Participants qualify under the following Medi-Cal Aid codes:

ARTICLE IV. MEDI-CAL AID DEFINITION & CODES

1. CASH GRANT

AID CODE		PROGRAM DEFINITION
10	AGED	SSI/SSP Aid to the Aged – Cash assistance program administered by the Social Security Administration, pays a cash grant to needy persons aged sixty-five (65) or older.
20	BLIND	SSI/SSP Aid to the Blind – Cash assistance program administered by the Social Security Administration, pays a cash grant to needy blind persons of any age.
60	DISABLED	SSI/SSP Aid to the Disabled – Cash assistance program administered by the Social Security Administration, pays a cash grant to needy persons who meet the federal definition of disability.

2. PICKLE ELIGIBLES/20 PERCENT SOCIAL SECURITY DISREGARDS

AID CODE		PROGRAM DEFINITION
**16	AGED	Aid to the Aged-Pickle Eligibles – Persons aged sixty-five (65) or older who were eligible for and receiving SSI/SSP and Title II Benefits concurrently in any month since April 1977 and were subsequently discontinued from SSI/SSP but would be eligible to receive SSI/SSP if their Title II cost-of-living increases were disregarded. These persons are eligible for Medi-Cal benefits as public assistance recipients in accordance with the provisions of the Lynch v. Rank lawsuit.

ARTICLE IV. MEDI-CAL AID DEFINITION & CODES (Continued)

**26	BLIND	Aid to the Blind-Pickle Eligibles – Persons who meet the federal criteria for blindness and are covered by the provision of the Lynch v. Rank lawsuit. See Aid Code 16 for definition of Pickle Eligibles.
**66	DISABLED	Aid to the Disabled-Pickle Eligibles – Persons who meet the federal definition of disability and are covered by the provision of the Lynch v. Rank lawsuit. See Aid Code 16 for definition of Pickle Eligibles.

**NOTE: This also includes persons who were discontinued from cash grant status due to the twenty percent (20%) Social Security increase under Public Law 32-336. These persons are eligible for Medi-Cal benefits as public assistance recipients in accordance with 22 CCR 50247.

3. MEDICALLY NEEDY/NO SHARE OF COST

AID CODE		PROGRAM DEFINITION
14	AGED-MN	Aid to the Aged-Medically Needy – Persons aged sixty-five (65) or older who do not wish or are not eligible for a cash grant but are eligible for Medi-Cal only. No share of cost required of the beneficiaries.
24	BLIND-MN	Aid to the Blind-Medically Needy – Persons who meet the federal definition of disability and do not wish or are not eligible for a cash grant but are eligible for Medi-Cal only. No share of cost required of the beneficiaries.
64	DISABLED MN	Aid to the Disabled-Medically Needy – Persons who meet the federal definition of disability and do not wish or are not eligible for a cash grant, but are eligible for Medi-Cal only. No Share of cost required of the beneficiaries.

4. MEDICALLY NEEDY/SHARE OF COST

AID CODE		PROGRAM DEFINITION
17	AGED-MN SOC	Aid to the Aged-Medically Needy, Share of Cost – See Aid Code 14 for definition of AGED-MN. Share of cost is required of the beneficiaries.
27	BLIND-MN	Aid to the Blind-Medically Needy, Share of Cost – SOC See Aid Code 24 for definition of BLIND-MN. Share of cost is required of the beneficiaries.
67	DISABLED MN-SOC	Aid to the Disabled-Medically Needy, Share of Cost – See Aid Code 64 for definition of Disabled-MN. Share of cost is required of the beneficiaries.

ARTICLE IV. MEDI-CAL AID DEFINITION & CODES (Continued)

5. AGED AND DISABLED FEDERAL POVERTY LEVEL PROGRAM

AID CODE		PROGRAM DEFINITION
1H	AGED	Aged persons who, due to their income levels, would normally be included in the Medi-Cal Share of Cost population (Aid Code 17). Under this new program, those recipients with a Share of Cost of $1 to $326 will be given full scope, no Share of Cost Medi-Cal.
6H	DISABLED	Disabled persons who, due to their income levels, would normally be included in the Medi-Cal Share of Cost population (Aid Code 17). Under this program, those recipients with a Share of Cost of $1 to $326 will be given full scope, no Share of Cost Medi-Cal.

6. INSTITUTIONAL DEEMING

AID CODE		PROGRAM DEFINITION
1X	NO SOC	MSSP Medi-Cal Qualified. Eligible due to application of spousal impoverishment rules.
1Y	SOC	MSSP Medi-Cal Qualified. Eligible due to application of spousal impoverishment rules. Share of cost is required of the beneficiaries. These recipients are identified apart from the regular Medi-Cal SOC population by the Special Program Aid Code of 1F.

7. CONTINUED ELIGIBILITY – REDETERMINATION

AID CODE		PROGRAM DEFINITION
1E	AGED	Continued eligibility for the Aged - Former SSI beneficiaries who are aged until the county redetermines their eligibility.
2E	BLIND	Continued eligibility for the Blind - Former SSI beneficiaries who are blind until the county redetermines their eligibility.
6E	DISABLED	Continued eligibility for the Disabled - Discontinued SSI beneficiaries who are disabled until the county redetermines their eligibility.

ARTICLE V. DEFINITIONS OF SERVICES PROVIDED UNDER THE WAIVER

Services Provided Under the Waiver – Contractors must have the ability to provide the following services to MSSP Waiver Participants:

Definitions of each of the services approved by the Centers for Medicare and Medicaid Services of the Department of Health and Human Services under the existing 1915(c) Home and Community-Based Services Waiver are as follows. The numbers in parentheses are program code designations for the particular service.

1. **Adult Day Care** (1.1): Will be provided to MSSP Waiver Participants who are identified in their plan of care as benefiting from being in a social setting with less intense supervision and fewer professional services than offered in an adult day health support center. Adult Day Care services will be provided when the Waiver Participant's plan of care indicates that the service is necessary to reach a therapeutic goal. Adult day care centers are community-based programs that provide nonmedical care to persons eighteen (18) years of age or older in need of personal care services, supervision, or assistance essential for sustaining the activities of daily living or for the protection of the individual on less than a 24-hour basis. The Department of Social Services (DSS) licenses these centers as community care facilities.

   Adult Day Care centers are subject to Federal Home and Community-Based Settings (HCBS) requirements, meaning they must:
   - Support access to the greater community;
   - Be selected by the Participant from among setting options;
   - Ensure individual rights of privacy, dignity and respect, and freedom from coercion and restraint;
   - Optimize autonomy and independence in making life choices;
   - Facilitate choice regarding services and who provides them; and
   - Be physically accessible.

   Vendor contracts with Adult Day Care centers must contain language that addresses Home and Community-Based Settings requirements as specified in 42 CFR 441.301(c)(4).

2. **Minor Home Repairs and Maintenance** (2.2): Minor Home Repairs do not involve structural changes or repairs to a dwelling. Maintenance is defined as those services necessary for accessibility (e.g., ramps, grab bars, handrails, items above what is covered by the State Plan, and installation), safety (e.g., electrical wiring, smoke alarms), or security (e.g., locks). Eligible Waiver Participants are those whose health and/or safety or independence are jeopardized because of deficiencies in their place of residence. This service is limited to Waiver Participants who are owners/occupiers of their own home, or those in rental housing where the owner refuses to make needed repairs or otherwise alter the residence to adapt to special Waiver Participant needs. Written permission from the landlord (including provision for removal of modifications, if necessary) is required before undertaking repairs or maintenance on leased premises. All services shall be provided in accordance with applicable State or local building codes.

ARTICLE V. DEFINITIONS OF SERVICES PROVIDED UNDER THE WAIVER (Continued)

3. **Non-medical Home Equipment** (2.3): Includes equipment and supplies which address a Waiver Participant's functional limitation and/or condition, are necessary to assure the Waiver Participant's health, safety, and independence, and are not otherwise provided through this Waiver or through the State Plan.

   Allowable items:
   Small appliances; large appliances; furniture; home safety devices; clothing=related items; paperwork-related items; organizing items; household items (items that are not specifically designed for home safety, but are necessary to maintain independence and safety in the home); kitchenware; bedding/bath items; exercise equipment; social support/therapeutic activity supplies; personal care items (items related to personal care and the prevention of skin breakdown); health-related supplies (items that have a health component, but are not covered by the State Plan); and incontinence supplies (gloves, wipes, washcloths and creams).

   Experimental or prohibited treatments are excluded as well as those items and services solely for entertainment or recreation. The costs associated with delivery and repairs of the items allowable under this service are also included.

4. **Community Transition Services-** (2.4): These services allow for non-recurring moving and/or set-up expenses for individuals who make the transition from an institution to their own home or apartment in the community. Eligible Waiver Participants are those who reside in a facility/institution or care provider-owned residence and are transitioning from a facility/institution to their own home or apartment in the community where the person is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include: (a) security deposits that are required to obtain a lease on an apartment or home; (b) essential household furnishings required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens; (c) set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; (d) services necessary for the Waiver Participant's health and safety such as pest eradication and one-time cleaning prior to occupancy; (e) moving services, which may include materials and necessary labor; (f) activities to assess need, arrange for and procure need resources. Community Transition Services do not include monthly rental or mortgage expense; food, regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes.

ARTICLE V. DEFINITIONS OF SERVICES PROVIDED UNDER THE WAIVER (Continued)

5. **Assistive Technology** (2.6): Assistive technology means an item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of participants. Assistive technology service means a service that directly assists a Waiver Participant in the selection, acquisition, or use of an assistive technology device. Assistive Technology includes: (A) the evaluation of the assistive technology needs of a Waiver Participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the Waiver Participant; (B) services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for participants; applying, maintaining, repairing, or replacing assistive technology devices; (C) services consisting of selecting, designing, fitting, customizing, adapting; (D) coordination and use of necessary therapies, interventions, or services with assistive technology devices, such as therapies, interventions, or services associated with other services in the care plan. The costs associated with delivery and repairs of the items allowable under this service are also included.

   Examples include, but are not limited to, a transfer pole, grabber/reacher, dressing aid or sock aid, etc.

6. **Supplemental Homemaker Services** (3.1): are for purposes of household support and applies to the performance of household tasks rather than to the care of the Waiver Participant. Homemaker activities are limited to: household cleaning, laundry (including the services of a commercial laundry or dry cleaner), shopping, food preparation, and household maintenance. Waiver Participant instruction in performing household tasks and meal preparation may also be provided.

   The care manager completes a health and psychosocial assessment which assess all Waiver Participant needs including the need for homemaker services and personal care. The assessments also consider IHSS services in place and whether the Waiver Participant's needs are being met.

   Supplemental Homemaker Services under the MSSP Waiver are limited to additional services not otherwise covered under the State Plan or under IHSS, but consistent with the Waiver objectives of avoiding institutionalization.

   Services purchased using 3.1 can supplement but not supplant IHSS.

7. **Supplemental Personal Care** (3.2): This service provides assistance to maintain bodily hygiene, personal safety, and activities of daily living (ADL). These tasks are limited to nonmedical personal services: feeding, bathing, oral hygiene, grooming, dressing, care of and assistance with prosthetic devices, rubbing skin to promote circulation, turning in bed and other types of

ARTICLE V. DEFINITIONS OF SERVICES PROVIDED UNDER THE WAIVER (Continued)

repositioning, assisting the individual with walking, and moving the individual from place to place (e.g., transferring). Waiver Participant instruction in self-care may also be provided; may also include assistance with preparation of meals but does not include the cost of the meals themselves.

Supplemental Personal Care under the MSSP Waiver is limited to additional services not otherwise covered under the State Plan or under IHSS, but consistent with the Waiver objectives of avoiding institutionalization. Services are provided when personal care services furnished under the approved State Plan limits are exhausted. The scope and nature of these services do not differ from personal care services furnished under the State Plan. The provider qualifications specified in the State Plan apply.

Services purchased using 3.2 can supplement but not supplant IHSS.

Personal care service providers may be paid while the Waiver Participant is institutionalized. This payment is made to retain the services of the care provider and is limited to seven (7) calendar days per institutionalization.

8. **Counseling & Therapeutic Services- Therapeutic Services** (3.3): This service addresses unmet needs of Waiver Participants when such care is not otherwise available under the State Plan. These services will be provided based on the following criteria: The Waiver Participant assessment identifies need for this support and the care plan reflects the required service(s). MSSP Waiver Participants are extremely frail and, on occasion, in need of services that cannot be provided under that cannot be provided under Medi-Cal. This MSSP service supplements but does not supplant benefits provided by the State Plan. Therapeutic Services includes the following: foot care, massage therapy, and swim therapy.

9. **Supplemental Protective Supervision** (3.7): Ensures provision of supervision in the absence of the usual care provider to persons residing in their own homes, who are very frail or otherwise may suffer a medical emergency. Such supervision serves to prevent immediate placement in an acute care hospital, skilled nursing facility, or other 24-hour care facility. Such supervision does not require medical skills and can be performed by an individual trained to summon aid in the event of an emergency. This service may also provide a visit to the Waiver Participant's home to assess a medical situation during an emergency (e.g., natural disaster). Waiver Service funds may not be used to purchase this service until existing county Title XX Social Services and Title XIX Medi-Cal resources have been fully utilized and an unmet need remains.

Waiver Participants that receive Supplemental Protective Supervision may also receive a room monitor under Communication: Device (9.2); however, are not allowed to also receive Emergency Response System (ERS) services.

Services purchased using 3.7 can supplement but not supplant IHSS.

ARTICLE V. DEFINITIONS OF SERVICES PROVIDED UNDER THE WAIVER (Continued)

10. **Care Management**: Assists Waiver Participants in gaining access to needed Waiver and other State Plan services, as well as needed medical, social, and other services, regardless of the funding source. Care managers are responsible for ongoing monitoring of the provision of services included in the Waiver Participant's plan of care. Additionally, care managers initiate and oversee the process of assessment and reassessment of Waiver Participant level of care and the monthly review of plans of care.

    a) **Care Management** (50): The MSSP care management system vests responsibility for assessing, care planning, authorizing, locating, coordinating, and monitoring a package of long-term care services for community-based Waiver Participants with a local MSSP site contractor and specifically with the site care management team. The care management teams at each of the local sites are trained professionals working under the job titles of nurse care manager and social work care manager; these professionals may be assisted by care manager aides. The teams are responsible for care management services including the assessment, care plan development, service authorization/delivery, monitoring, and follow-up components of the program. Case records must document all Waiver Participant contact activity each month.

    b) **Deinstitutional Care Management (DCM)** (4.6): This service is used ONLY with individuals who are institutionalized. It allows care management and Waiver Services to begin up to one hundred eighty (180) days prior to an individual's discharge from an institution. It may be used in two situations, as follows:

        - Where MSSP has gone into a facility (nursing facility or acute hospital) to begin working with a resident to facilitate their discharge into the community
        - Where an established MSSP Waiver Participant is institutionalized and MSSP services are necessary for the person to be discharged back into the community

    In either situation, all services (monthly Administration and Care Management, plus any purchased services) provided during this period are combined into one unit of DCM and billed upon discharge. For those individuals who do not successfully transition to the Waiver, all services provided are combined into one unit of DCM and billed at the end of the month in which the decision is made to cease MSSP activity. For those individuals who do not successfully transition to the Waiver, billing is disallowed, as Federal Financial Participation (FFP) cannot be claimed for DCM services where the participant does not transition into the Waiver. No care management services available under the State Plan will be duplicated under the MSSP Waiver.

ARTICLE V. DEFINITIONS OF SERVICES PROVIDED UNDER THE WAIVER (Continued)

11. **Consultative Clinical Services** (4.3): This service addresses the unmet needs of Waiver Participants when such care is not otherwise available under the State Plan. These services will be provided based on the following criteria:

    - The Waiver Participant assessment identifies need for this support and the care plan reflects the required service(s).

    - MSSP utilizes all of the services available under the State Plan prior to purchasing these services as Waiver Services. MSSP's Waiver Participants are extremely frail and, on occasion, in need of services that cannot be provided under Medi-Cal. This service is especially critical for persons recently discharged from acute hospitals or who are otherwise recovering at home from an acute illness or injury. This MSSP service supplements, but does not supplant, benefits provided by the State Plan.

    In addition to the provision of care, Waiver Participants and their families/caregivers are trained in techniques which will enable them (or their caregivers) to carry out their own care whenever possible.

    Allowable services are:
    • Social services consultation
    • Legal and paralegal professionals' consultation
    • Dietitian/Nutrition consultation
    • Pharmacy consultation
    • Vital sign monitoring

12. **Respite** (5.1, 5.2): The State Plan does not provide for respite care. "Respite care services shall be subject to EVV requirements required by Subsection (l) of Section 1903 of the Social Security Act (SSA) (42 U.S.C. 1396b)." By definition, the purpose of respite care is to relieve the Waiver Participant's informal caregiver and thereby prevent breakdown in the informal support system. Respite service will include the supervision and care of a Waiver Participant, while the family or other individuals who normally provide primary care take short-term relief or respite which allows them to continue as caregivers. Respite may also be needed in order to cover emergencies and extended absences of the caregiver. As dictated by the Waiver Participant's circumstances, services will be provided In-Home (5.1) or Out-of-Home (5.2) through appropriate available resources such as board and care facilities, skilled nursing facilities, etc. Federal Financial Participation will not be claimed for the cost of room and board except when provided as part of respite care in a facility approved by the State that is not a private residence. Individuals providing services in the Waiver Participant's residence shall be trained and experienced in homemaker services, personal care, or home health services, depending on the requirements in the Waiver Participant's plan of care.

ARTICLE V. DEFINITIONS OF SERVICES PROVIDED UNDER THE WAIVER (Continued)

13. **Transportation** (6.3 and 6.4): These services provide access to the community (e.g., non-emergency medical transportation to health and social service providers) and special events for Waiver Participants who do not have means for transportation or whose mobility is limited, or who have functional disabilities requiring specialized vehicles and/or escort. These services are in contrast to the transportation service authorized by the State Plan which is limited to medical services, or Waiver Participants who have documentation from their physician that they are medically unable to use public or ordinary transportation. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge will be utilized.

    Transportation services are usually provided under public paratransit or public social service programs (e.g., Title III of the Older Americans Act) and shall be obtained through these sources without the use of MSSP resources, except in situations where such services are unavailable or inadequate. Service providers may be paratransit subsystems or public mass transit; specialized transport for the older adults and adults with disabilities; private taxicabs where no form of public mass transit or paratransit is available or accessible; or private taxicabs when they are subsidized by public programs or local government to service frail older adults and handicapped (e.g., in California, some counties provide reduced fare vouchers for trips made via private taxicabs for frail older adults and handicapped).

    Escort services will be provided when necessary to assure the safe transport of the Waiver Participant. Escort services may be authorized for those Waiver Participants who cannot manage to travel alone and require assistance beyond what is normally offered by the transportation provider. This service will be provided by trained paraprofessionals or professionals, depending on the Waiver Participant's condition and care plan requirements.

14. **Nutritional Services** (7.1, 7.2, and 7.3): These services may be provided daily, but are not to constitute a full nutritional regimen (three (3) meals a day).

    a) **Congregate Meals** (7.1): Meals served in congregate meal settings for Waiver Participants who are able to leave their homes or require the social stimulation of a group environment in order to maintain a balanced diet. Congregate meals can be a preventive measure for the frail older person who has few (if any) informal supports, as well as a rehabilitative activity for people who have been physically ill or have suffered emotional stress due to losses associated with aging. This service should be available to MSSP Waiver Participants through Title III of the Older Americans Act. MSSP funds shall only be used to supplement congregate meals when funding is unavailable or inadequate through Title III or other public or private sources.

        Congregate Meal Sites are subject to Federal Home and Community-Based Settings (HCBS) requirements, meaning they must:

ARTICLE V. DEFINITIONS OF SERVICES PROVIDED UNDER THE WAIVER (Continued)

- Support access to the greater community;
- Be selected by the participant from among setting options;
- Ensure individual rights of privacy, dignity and respect, and freedom from coercion and restraint;
- Optimize autonomy and independence in making life choices;
- Facilitate choice regarding services and who provides them; and
- Be physically accessible.

Vendor contracts with Congregate Meal Sites must contain language that addresses Home and Community-Based Settings requirements as specified in 42 CFR 441.301(c)(4).

b) **Home Delivered Meals** (7.2): Meals for Waiver Participants who are homebound, unable to prepare their own meals and have no caregiver at home to prepare meals for them. As with Congregate Meals, the primary provider of this service is Title III of the Older Americans Act. MSSP funds shall only be used to supplement home-delivered meals when they are unavailable or inadequate through Title III or other public or private sources.

c) Oral Nutritional Supplements (7.3): If oral nutritional supplements (ONS) are to be purchased using Waiver Service funds, the following actions must occur and be documented in the Participant record:

- The Nurse Care Manager (NCM) must assess the Waiver Participant's nutritional needs and determine that an ONS is advisable.
- The use of home-prepared drinks/supplements (instant breakfast, pureed food) has been explored and found not to meet the Participant's needs.
- All other options for payment of an ONS have been exhausted (Waiver Participant, family, etc.).

If all three criteria have been satisfied, an ONS may be purchased initially for a period of three (3) months. If an ONS needs to be continued beyond the three-month timeframe, a physician order must be obtained. Upon annual reassessment, if all criteria, including a new nutritional screen, are satisfied and the previous physician order has expired, another three months may be purchased. The physician's order must be renewed on an annual basis.

15. **Counseling & Therapeutic Services** (8.3, 8.4, and 8.5): These services include protection for Waiver Participants who are isolated and homebound due to health conditions; who suffer from depression and other psychological problems; individuals who have been harmed or threatened with harm (physical or mental) by other persons or by their own actions; or those whose cognitive functioning is impaired to the extent they require assistance and support in

ARTICLE V. DEFINITIONS OF SERVICES PROVIDED UNDER THE WAIVER (Continued)

making and carrying out decisions regarding personal finances.

a. **Social Support** (8.3): Includes periodic telephone contact, visiting, or other social and reassurance services to verify that the individual is not in medical, psychological, or social crisis, or to offset isolation. Such services shall be provided based on need, as designated in the Waiver Participant's plan of care. The MSSP has found that isolation and lack of social interaction can seriously impact some Waiver Participants' capacity to remain independent. Lack of motivation or incentive or the lack of any meaningful relationships can contribute to diminishing functional capacity and premature institutionalization.

   These services are often provided by volunteers or through Title III of the Older Americans Act; however, these services may not be available in a particular community and do, infrequently, require purchase. The Waiver will be used to purchase friendly visiting only if the service is unavailable in the community or is inadequate as provided under other public or private programs.

b. **Therapeutic Counseling** (8.4): Includes individual or group counseling to assist with social, psychological, or medical problems which have been identified in the assessment process and included in the Waiver Participant's care plan. The MSSP has found that therapeutic counseling is essential for preventing some Waiver Participants from being placed in a nursing facility. This service may be utilized in situations where Waiver Participants or their caretakers may face crises, severe anxiety, emotional exhaustion, personal loss/grief, confusion, and related problems. Counseling by licensed or certified counselors in conjunction with other services (e.g., respite, IHSS, meals) may reverse some states of confusion and greatly enhance the ability of a family to care for the Waiver Participant in the community or allow the Waiver Participant to cope with increasing impairment or loss.

c. **Money Management** (8.5): This service assists the Waiver Participant with activities related to managing money and the effective handling of personal finances. Services may be either periodic or as full-time substitute payee. Services may be provided by organizations or individuals specializing in financial management or performing substitute payee functions.

16. **Communication (9.1 and 9.2)**: Waiver Participants who receive these services are those with special communication problems such as vision, hearing, or speech impairments and persons with physical impairments likely to result in a medical emergency. Services shall be provided by organizations such as: speech and hearing clinics; organizations serving blind individuals; hospitals; senior citizens centers; and providers specializing in communications equipment for disabled or at-risk persons. Services shall be available on a routine or emergency basis as designated in the Waiver Participant's plan of care.

ARTICLE V. DEFINITIONS OF SERVICES PROVIDED UNDER THE WAIVER (Continued)

a. **Translation** (9.1): The provision of translation and interpretive services for purposes of instruction, linkage with social or medical services, and conduct of business is essential to maintaining independence and carrying out the ADL and Instrumental Activities of Daily Living (IADL) functions.

For non-English speaking Waiver Participants, this service is the link to the entire in-home and community-based service delivery system. MSSP resources shall be used to support this service only where family and community resources are unable to meet the need, and as described in the care plan.

b. **Device** (9.2): The rental/purchase of 24-hour emergency assistive services, or installation of a telephone to assist in communication (excluding monthly telephone charges) for Waiver Participants who are at risk of institutionalization due to physical conditions likely to result in a medical emergency. Purchase of Emergency Response Systems (ERS) is limited to those Waiver Participants who live alone, or who are alone for significant parts of the day and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision. The following are allowable:

(i) 24-hour answering/paging
(ii) Medic-alert type bracelets/pendants
(iii) Intercoms
(iv) Emergency Response System
(v) Room/two-way monitors
(vi) Light fixture adaptations (blinking lights, etc.)
(vii) Telephone adaptive devices not available from the telephone company

This service is limited to additional services and items not otherwise covered under the State Plan but are consistent with Waiver objectives of avoiding institutionalization. Telephone installation or reactivation of service will only be authorized to enable the use of telephone-based electronic response systems where the Waiver Participant has no telephone, or for the isolated Waiver Participant who has no telephone and who resides where the telephone is the only means of communicating health needs. This service will only be authorized when the Waiver Participant has a medical/health condition that makes him/her vulnerable to medical emergency.

Waiver Participants that receive Supplemental Protective Supervision may also receive a room monitor under Communication: Device; however, are not allowed to also receive ERS services. These types of devices are intended to assist in keeping at-risk Waiver Participants safe in the home and are not intended to replace an in-person support staff.

ARTICLE VI. ELECTRONIC VISIT VERIFICATION (EVV)

1. Electronic Visit Verification (EVV) is a telephone and computer-based solution validating that in-home service visits occur. EVV solutions shall verify the: a) type of service performed; b) individual receiving the service; c) date of the service; d) location of service delivery; e) individual providing the services; and f) time the service begins and ends.

2. Pursuant to Subsection (l) of Section 1903 of the Social Security Act (SSA) (42 U.S.C. 1396b), Contractor shall implement DHCS-approved Electronic Visit Verification (EVV) solutions for Medicaid-funded personal care services and home health care services. Contractor and subcontractors shall use safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of PHI and other confidential data and comply, where applicable, with subpart C of 45 CFR Part 164 to prevent use or disclosure of the information as provided for by this Agreement.

ARTICLE I. INVOICING AND PAYMENT

A. To receive payment under the fee-for-service (FFS) payment model, the Contractor shall prepare and submit electronic claims through the State's Fiscal Intermediary (FI) as set forth in the Medi-Cal Provider Manual.

B. Payments shall be made in accordance with the following provisions:

1. The Contractor shall submit claims to Medi-Cal FI, based upon the month of service and only for actual expenses. On each claim, the Contractor shall show the amount billed for each service code

2. Failure to provide data and reports specified by this Agreement will result in the delay of payment of invoices

C. Payment will be made in accordance with, and within the time specified in, California Government Code, Chapter 4.5, commencing with Section 927.

D. Reimbursement for Performance

The Contractor shall be entitled to monthly payment for actual services delivered to the Contractor's monthly active participants. This amount may vary from month to month but total annual payments to the Contractor shall not exceed the amount of the Contractor's total participant slot budget for the year.

E. Rate Adjustment

Any rate adjustments must be submitted to CDA for approval. The rate change request should be submitted to MSSPService@aging.ca.gov and include the following information in their rate change request:

- Billing Code
- Effective Date
- Current Rate
- Requested Rate

F. Advance Payments

1. CDA may authorize an advance payment during the term of the Agreement pursuant to the Welfare and Institutions Code Section 9566 for Contractors providing services under the FFS payment model. Upon approval of this Agreement, the Contractor may request an advance not to exceed twenty-five percent (25%) of the total contract amount.

2. A request for an advance payment shall be on the Contractor's letterhead and include both an original signature of authorized designee and the Agreement number. Requests for advances will not be accepted after the first day of that fiscal year unless otherwise authorized by CDA.

3. Any funds advanced under this Agreement, plus interest earned on same, shall be deducted from amounts due the Contractor. If, after settlement of the Contractor's final claim, the California Department of Health Care Services (DHCS) or CDA determines an amount is owed DHCS or CDA hereunder, DHCS or CDA shall notify the Contractor and the Contractor shall refund the requested amount within ten (10) working days of the date of the State's request.

4. The Contractor may at any time repay all or any part of the funds advanced hereunder. Whenever either party gives prior written notice of termination of this Agreement, the Contractor shall repay to DHCS, within ten (10) working days of such notice, the unliquidated balance of the advance payment.

5. Repayment of advances will be recovered from claims submitted to the State's FI after January 1st of each fiscal year and be collected at fifty percent (50%) of each claim submitted until the amount advanced is repaid. The Contractor may at any time be required to repay to DHCS all or any part of the advance.

6. Repayment of any remaining advances funds not collected through the process described in subsection 6 above, will be recovered through the Closeout process.

ARTICLE II. FUNDS

A. Expenditure of Funds

1. The Contractor shall expend all funds received hereunder in accordance with this Agreement.

2. Any reimbursement for authorized travel and per diem shall be at rates not to exceed those amounts paid by the State in accordance with the California Department of Human Resources' (CalHR) rules and regulations.

ARTICLE II. FUNDS (Continued)

In State:

- Mileage/Per Diem (meals and incidentals)/Lodging

Out of State:

- Travel and Relocation Policy-Human Resource Manual

This is not to be construed as limiting the Contractor from paying any differences in costs, from funds other than those provided by CDA, between the CalHR rates and any rates the Contractor is obligated to pay under other contractual agreements. No travel outside the State of California shall be reimbursed unless prior written authorization is obtained from the State. [2 CCR 599.615 et seq.]

The Contractor agrees to include these requirements in all contracts it enters into with subcontractors/vendors to provide services pursuant to this Agreement.

3. DHCS and CDA reserve the right to refuse payment to the Contractor or later disallow costs for any expenditure as determined by DHCS or CDA to be out of compliance with this Agreement; unrelated or inappropriate to contract activities; when adequate supporting documentation is not presented; or where prior approval was required but was either not requested or granted.

4. The Contractor agrees that any refunds, rebates, credits, or other amounts (including any interest thereon) accruing to or received by the Contractor under this Contract, shall be paid by the Contractor to DHCS to the extent that they are properly allocable to costs for which the Contractor has been reimbursed by DHCS under this Contract.

5. CDA may require prior approval and may control the location, cost, dates, agenda, instructors, instructional materials, and attendees at any reimbursable training seminar workshop or conference conducted by the Contractor in relation to the program funded through this Contract. CDA may also maintain control over any reimbursable publicity, or education materials to be made available for distribution. The Contractor is required to acknowledge the support of CDA in writing, whenever publicizing the work under this Agreement in any media.

ARTICLE II. FUNDS (Continued)

6. Any overpayment of funds must be deposited into an interest-bearing account.

B. The Contractor shall maintain accounting records for funds received under the terms and conditions of this Agreement. These records shall be separate from those for any other funds administered by the Contractor and shall be maintained in accordance with Generally Accepted Accounting Principles and Procedures and Office of Management and Budget's– Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards. [2 CFR Part 200]

C. Upon termination, cancellation, or expiration of this Agreement or dissolution of the entity, the Contractor, upon written demand, shall immediately return to DHCS any funds provided under this Agreement, which are not payable for goods or services delivered prior to the termination, cancellation, or expiration of this Agreement or the dissolution of the entity.

D. Interest Earned

1. Interest earned on federal advance payments deposited in interest-bearing accounts must be remitted annually to the Department of Health and Human Services, Payment Management System, Rockville, MD 20852. Interest amounts up to $500 per year may be retained by the non-Federal entity for administrative expense. [2 CFR § 200.305(b)(9)]

2. The Contractor must maintain advance payments of Federal awards in interest-bearing accounts, unless the following apply.

   a. The Contractor receives less than $120,000 in Federal awards per year.

   b. The best reasonably available interest-bearing account would not be expected to earn interest in excess of $500 per year on federal cash balances.

   c. The depository would require an average or minimum balance so high that it would not be feasible within the expected federal and non-federal cash resources.

   d. A foreign government or banking system prohibits or precludes interest bearing accounts.

ARTICLE III. BUDGET AND BUDGET REVISION

Payment for performance by the Contractor under this contract may be dependent upon the availability of future appropriations by the Legislature or Congress for the purposes of this contract. No legal liability on the part of the State for any payment may arise under this contract until funds are made available and until the Contractor has received notice of funding availability, which will be confirmed in writing.

A. Funding Reduction in Subsequent Fiscal Years

1. If funding for any State fiscal year is reduced or eliminated by the Legislature, Congress, or Executive Branch of State Government for the purposes of this program, the State shall have the option to either:

   a. Terminate the Contract pursuant to Exhibit D, Article XII
   b. Offer a contract amendment to the Contractor to reflect the reduced funding for this contract

2. In the event that the State elects to offer an amendment, it shall be mutually understood by both parties that the State reserves the right to determine which contracts, if any, under this program shall be reduced and that some contracts may be reduced by a greater amount than others. The State shall determine, at its sole discretion, the amount that any or all of the contracts shall be reduced for the fiscal year.

B. The Contractor shall be reimbursed for Waivers Services expenses only as itemized in the most recent approved or revised Budget. Care Management and Care Management Support categories shall be reimbursed up to the combined budget amount of both categories.

C. Category amounts stipulated in the Budget, a part of Exhibit B, are the maximum amounts that may be reimbursed by DHCS under this Agreement or the actual category expenditures whichever is less. The Care Management and Care Management Support categories will be treated as a combined total budget for determining maximum allowable reimbursement amount.

D. The budget shall include the following line items:

1. Personnel Costs - monthly, weekly, or hourly rates, as appropriate and personnel classifications together with the percentage of time to be charged to this Agreement.

2. Fringe Benefits.

ARTICLE III. BUDGET AND BUDGET REVISION (CONTINUED)

3. Consultation, Professional Services-Contractual Costs, subcontract, and consultant cost detail.

4. Facility, Rent & Operations – specify square footage and rate.

5. Equipment - detailed descriptions and unit costs.

6. Travel (Include: In State and Out of State) – mileage reimbursement rate, lodging, per diem and other costs.

7. Supplies.

8. Indirect Costs shall not exceed fifteen percent (15%) of direct salaries plus benefits.

9. Other Costs - a detailed list of other operating expenses.

E. The Contractor shall obtain prior written approval from CDA to transfer funds between the Care Management and Care Management Support categories if the transfer amount is equal to or greater than five (5) percent of either category of the approved budget. This request shall be submitted on a Revised Budget Form. The Contractor must provide justification and supporting documentation for the requested revision.

F. Budgeting processes and conditions will be subject to instructions that will be issued to the Contractor under separate cover.

G. Equipment/Property with per unit cost of $5,000 or more, all computing devices regardless of cost (including but not limited to, workstations, servers, laptops, personal digital assistants, notebook computers, tablets, smartphones, and cellphones), and all portable electronic storage media regardless of cost (including but not limited to, thumb/flash drives and portable hard drives) requires justification and approval from CDA and must be included in its approved MSSP budget.

ARTICLE IV. DEFAULT PROVISIONS

The State, without limiting any rights which it may otherwise have, may, at its discretion and upon written notice to the Contractor, withhold further payments under this Agreement, and/or demand immediate repayment of the unliquidated balance of any advance payment hereunder, upon occurrence of any one of the following events:

A. Termination or suspension of this Agreement

ARTICLE IV. DEFAULT PROVISIONS (CONTINUED)

B. A finding by the State that the Contractor:

1. Has failed to observe any of the covenants, conditions, or warrants of these provisions, or has failed to comply with any material provisions of this Agreement; or

2. Has failed to make progress, or is in such unsatisfactory financial condition, as to endanger performance of this Agreement; or

3. Has allocated inventory to this Agreement substantially exceeding reasonable requirements; or

4. Is delinquent in payment of taxes or of the cost of performance of this Agreement in the ordinary course of business

C. Appointment of a trustee, receiver, or liquidator for all or a substantial part of the Contractor's property, or institution of bankruptcy, reorganization, or arrangement of liquidation proceedings by or against the Contractor.

D. Service of any writ of attachment, levy, or execution, or commencement of garnishment proceeding or

E. The commission of an act of bankruptcy.

ARTICLE I. SUBCONTRACTING PROVISIONS SPECIFIC TO THIS MSSP AGREEMENT

A. Contractor shall ensure that all subcontractors of Waiver Services complete a CDA-approved Vendor Application.

B. Contractor shall ensure that the subcontractor's selection process is based upon equitable criteria that provides for adequate publicity, screens out unqualified subcontractors who would not be able to provide the needed services and provide for awards to the lowest responsible and responsive bidder(s) as defined in California State Contracting Manuals.

C. Subcontracts for Purchased Waiver Services shall consist of standard format language consistent with this Agreement.

D. Subcontracts shall require all subcontractors to report immediately in writing to the Contractor any incidents of fraud or abuse to Waiver Participants, in the delivery of services, in subcontractors' operations.

E. Contractor shall require all subcontractors to comply with the Health Insurance Portability and Accountability Act (HIPAA) Business Associate requirements in Exhibit F, as it appropriately relates to services rendered.

F. Contractors shall ensure all subcontractors comply with Electronic Visit Verification (EVV) requirements pursuant to federal and state law. Updated guidance may be obtained through DHCS, the state department overseeing EVV implementation.

G. The Contractor shall make timely payments to its subcontractors under this Agreement.

ARTICLE II. RECORDS PROVISIONS SPECIFIC TO THIS MSSP AGREEMENT

Waiver Participant records are to be kept as long as the case is open and active. Following case termination, Waiver Participant records will be maintained for a period of seven (7) years following case closure, or for a longer period if deemed necessary by CDA. A longer period of retention may be established by individual sites.

ARTICLE III. PROPERTY PROVISIONS SPECIFIC TO THIS MSSP AGREEMENT

A physical inventory of the property must be taken, and the results reconciled with the property records at least once every two (2) years.

ARTICLE IV. AUDIT REQUIREMENT PROVISIONS SPECIFIC TO THIS MSSP AGREEMENT

A. Unless prohibited by law, the cost of audits completed in accordance with provisions of Single Audit Act Amendments of 1996, are allowable charges to Federal Awards. The costs may be considered a direct cost, or an allocated indirect cost, as determined in accordance with provisions of applicable OMB cost principal circulars.

ARTICLE IV. AUDIT REQUIREMENT PROVISIONS SPECIFIC TO THIS MSSP AGREEMENT (Continued)

B. The Contractor may not charge to federal awards the cost of any audit under the Single Audit Act Amendments of 1996 not conducted in accordance with the Act.

C. CDA and DHCS shall have access to all audit reports of Contractors and have the option to perform audits and/or additional work, as needed.

D. All audits shall be performed in accordance with and address all issues contained in any federal OMB Compliance Supplement that applies to this program.

E. The Contractor shall include in its contract with an independent auditor a clause permitting access by the State to the work papers of the independent auditor.

F. Audits to be performed shall be, minimally, financial and compliance audits, and may include economy and efficiency and/or program results audits.

G. The Contractor shall cooperate with, and participate in, any further audits which may be required by DHCS.

H. The Contractor agrees that CDA, DHCS, the Department of General Services, the California State Auditor, or their designated representative shall, at all times, have the right to review and to copy any records and supporting documentation pertaining to the performance of this Agreement. Contractor agrees to maintain such records for possible audit for a minimum of three (3) years after final payment unless a longer period of records retention is required and until after CDA's Audits and Risk Management Branch has completed an audit. The Contractor agrees to provide CDA or its delegate with any relevant information requested and shall permit the awarding agency or its delegate access to its premises, upon reasonable notice, during normal business hours for the purpose of interviewing employees and inspecting and copying such books, records, accounts, and other material that may be relevant to a matter under investigation for the purpose of determining compliance with Government Code, Section 8546.7 et seq. Further, the Contractor agrees to include a similar right of CDA and DHCS to audit records and interview staff in any subcontract related to performance of this Agreement. [Cal. Gov. Code § 8546.7, Cal. Pub. Con. Code 10115 et seq.], [CCR Title 2, Section 1896]

I. The Catalog of Federal Domestic Assistance Number is 93.778, Grantor Medical Assistance Program.

ARTICLE V. TERMINATION OBLIGATIONS SPECIFIC TO THIS MSSP AGREEMENT

A. After the California Department of Aging's (CDA) Notice of Termination or the Contractor's Notice of Intent to Terminate (pursuant to Exhibit D, Article XII of this Agreement) and except as directed by CDA, the Contractor shall immediately proceed

ARTICLE V. TERMINATION OBLIGATIONS SPECIFIC TO THIS MSSP AGREEMENT (Continued)

with the following obligations, as applicable, regardless of any delay in determining or adjusting any funds due under this clause.

The Contractor shall:

1. Take immediate steps to ensure the health and safety of Waiver Participants in MSSP managed by the Contractor. Contractor agrees to refer MSSP Waiver Participants to other local resources.

2. Maintain staff to provide services to Waiver Participants during the course of Waiver Participant transition.

3. Deliver updated Waiver Participant records to the subsequent MSSP contractor or as directed by CDA.

4. With assistance from CDA, develop a written Transition Plan to locate alternative services for each Waiver Participant through another MSSP site or community agency in accordance with this Agreement.

5. Be responsible for providing all necessary Waiver Participant services until termination or expiration of the Contract and shall remain liable for the processing and payment of invoices and statements for covered services provided to Waiver Participants prior to such expiration or termination.

6. Submit a full accounting and closeout of the Contractor's existing budget.

7. Place no further subcontracts/vendor agreements for materials, or services, except as necessary to complete the continued portion of the Contract.

8. Settle all outstanding liabilities and termination settlement proposals arising from the termination of subcontracts/vendor agreements (the approval or ratification of which will be final for purposes of this clause).

9. Submit a Transition Plan as specified in Article VII of this Exhibit.

ARTICLE VI. INFORMATION INTEGRITY AND SECURITY PROVISIONS SPECIFIC TO THIS MSSP AGREEMENT

A. Contractor acknowledges that it has been provided a copy of the Health Insurance Portability and Accountability Act (HIPAA) Business Associate Agreement between CDA and DHCS ("Exhibit F"). Contractor, and its Subcontractors/Vendors, agrees that it must meet the requirements imposed on CDA, and all applicable provisions of HIPAA, the HITECH Act, the HIPAA regulations, and the Final Omnibus Rule, including the requirement to implement reasonable and appropriate administrative, physical, and technical safeguards to protect PHI and PI.

ARTICLE VI. INFORMATION INTEGRITY AND SECURITY PROVISIONS SPECIFIC TO THIS MSSP AGREEMENT (Continued)

B. Contractor, and its Subcontractors/Vendors, agrees that any security incidents or breaches of unsecured PHI or PI will be immediately reported to DHCS in the manner described in Exhibit F.

ARTICLE VII. TRANSITION PLANS SPECIFIC TO THIS MSSP AGREEMENT

A. The Contractor shall submit a transition plan to CDA within fifteen (15) days of delivery of the written Notice to Terminate the Contract (pursuant to Exhibit D, Article XII of this Agreement). The Transition Plan must be approved by CDA and shall, at a minimum, include the following:

1. A current Waiver Participant count and identifying Waiver Participant information upon request.

2. A description of how Waiver Participants will be notified about the change in their MSSP provider.

3. A plan to communicate with other MSSP sites, local agencies and advocacy organizations that can assist in locating alternative services for MSSP Waiver Participants.

4. A plan to inform community referral sources of the pending termination of this MSSP contract and what alternatives, if any, exist for future referrals.

5. A plan to evaluate the health and safety of Waiver Participants in order to assure appropriate placement.

6. A plan to transfer confidential Waiver Participant records to a new contractor or care management agency.

7. A plan to maintain adequate staff to provide continued care to MSSP Waiver Participants through the term of the Contract.

8. A full inventory and plan to dispose or, transfer, or return to CDA all property purchased during the entire operation of the Contract.

9. Additional information as necessary to affect a safe transition of Waiver Participants to other MSSP or community care management programs.

B. The Contractor shall implement the Transition Plan as approved by CDA. CDA will monitor the Contractor's progress in carrying out all elements of the Transition Plan.

ARTICLE VII. TRANSITION PLANS SPECIFIC TO THIS MSSP AGREEMENT (Continued)

C. If the Contractor fails to provide and implement a transition plan as required by Section A of this Article, the Contractor agrees to implement a transition plan submitted by CDA to the Contractor following the Contractor's Notice of Termination.

D. Phase-out Requirements for this Agreement:

1. Consist of the processing, payment, and monetary reconciliation necessary to pay claims for Waiver Services.

2. Consist of the resolution of all financial and reporting obligations of the Contractor. The Contractor shall remain liable for the processing and payment of invoices and other claims for payment for Waived Services and other services provided to Waiver Participants pursuant to this Contract prior to the expiration or termination. The Contractor shall submit to CDA all reports required.

3. Require all data and information provided by the Contractor to CDA be accompanied by a letter, signed by the responsible authority, certifying, under penalty of perjury, to the accuracy and completeness of the materials supplied.

ARTICLE VIII. REPORTING REQUIREMENTS SPECIFIC TO THIS MSSP AGREEMENT

A. The Contractor shall submit written reports, on a format prescribed by the State, to the State, as follows:

1. Quarterly Status Reports

a. Reports are due no later than the 30th of the month, following the close of the quarter unless otherwise specified by CDA.

b. Reports are a snapshot of each quarter and shall include an overview of significant developments during the report period, identified problems, and solutions. The report narrative should be concise and informative. The subject areas to be addressed are:

- Care Management Staffing – Including the Full Time Equivalent (FTEs) for each position and staffing ratio. Also including staff exemptions and self-certification of staff meeting program requirements

- Care Management Activity – Including staff turnover, training, quality assurance, Waiver Participant grievances and Fair Hearings, Critical Incident reporting, internal/external program reviews and corrective action plans, Waiver Participant satisfaction surveys, policy changes, and contract compliance regarding contracted caseload

ARTICLE VIII. REPORTING REQUIREMENTS SPECIFIC TO THIS MSSP AGREEMENT (Continued)

- Management Information System – Problems/issues with the Medi-Cal fiscal intermediary billing system and Medi-Cal fiscal intermediary technical support
- Monthly Active Waiver Participant Count
- Staff Roster
- Self-Certified Training
- Wait List – Including the number of potential MSSP Participants waiting for enrollment
- Critical Incident Reporting – Report is used for the entire fiscal year and is submitted quarterly for review by CDA. The report shall include all critical incidents, and the status should be updated in each quarter for any previously listed incidents. The comments section should be concise, but informative, and provide detail of the incident that occurred with actions or interventions placed with corresponding dates.
- Fiscal Reporting – Expenditure data by budget category and receivables by budget category

2. Ad Hoc Reports

The Contractor shall submit Ad Hoc Reports as may be required from time to time by CDA. Typical subject areas may include, but are not limited to:

a. General site operations
b. Facility and equipment
c. Emergency care
d. Availability of care
e. Waiver Participant satisfaction
f. MIS operations
g. Administrative procedures
h. Database
i. Possible noncompliance with this Agreement
j. Fiscal year closeout

ARTICLE VIII. REPORTING REQUIREMENTS SPECIFIC TO THIS MSSP AGREEMENT (Continued)

3. Fiscal Closeout Reports

   As part of the closeout procedures for this contract, the Contractor shall submit a closeout package which must include the following documents:

   a. Final Accounting Reconciliation
   b. Closeout Budget
   c. Fiscal Summary Report for the State

   CDA will transmit specific closeout instructions, including the Closeout Report due dates.

4. Monthly Active Waiver Participant Count

   Reports are due on the 5th working day of each month, unless otherwise specified by CDA.

B. The Contractor, at its discretion, may at any time prepare and submit reports and correspondence to CDA summarizing problems and concerns.