409

SUBMITTAL TO THE BOARD OF SUPERVISORS
COUNTY OF RIVERSIDE, STATE OF CALIFORNIA

FROM: Department of Mental Health

SUBMITTAL DATE:
March 6,2014

SUBJECT: Ratify the Participation Agreement with California Mental Health Services Authority (CalMHSA) and the Memorandum of Understanding (MOU) between CalMHSA, Department of Mental Health (DMH) and the Department of State Hospitals (DSH) for the Procurement of State Hospital Beds for FY 13/14. (District: All) [$2,970,735 Ongoing] State.

RECOMMENDED MOTION: That the Board of Supervisors ratify and:

1. Approve the FY 13/14 Participation Agreement Number 118-2013-SHB-RC1 between the DMH and CalMHSA;
2. Approve the FY 13/14 MOU between CalMHSA, DMH and the DSH for the Procurement of State Hospital Beds;
3. Authorize the Chairman of the Board to sign the MOU and Participation Agreement; and
4. Authorize the Director of Mental Health to sign ministerial amendments to the Participation Agreement with CalMHSA through June 30, 2017.

BACKGROUND:
Summary
(Continue on Page 2)

JW: KAS

Jerry Wengerd, Director
Department of Mental Health

FINANCIAL DATA	Current Fiscal Year:	Next Fiscal Year:	Total Cost:	Ongoing Cost:	POLICY/CONSENT (per Exec. Office)
COST	$ 2,970,735	$ 2,970,735	$ 11,882,940	$ 2,970,735	Consent ☐ Policy ✓
NET COUNTY COST	$ 0	$ 0	$ 0	$ 0	

SOURCE OF FUNDS: State – 100%

Budget Adjustment: NO

For Fiscal Year: 13/14

C.E.O. RECOMMENDATION: APPROVE

County Executive Office Signature BY: Jennifer L. Sargent

MINUTES OF THE BOARD OF SUPERVISORS

On motion of Supervisor Stone, seconded by Supervisor Tavaglione and duly carried by unanimous vote, IT WAS ORDERED that the above matter is approved as recommended.

Ayes: Jeffries, Tavaglione, Stone, Benoit and Ashley
Nays: None
Absent: None
Date: May 6, 2014
xc: Mental Health

Kecia Harper-Ihem
Clerk of the Board
By: Deputy

Prev. Agn. Ref.:	District:	Agenda Number:
		3-12

☐ Positions Added ☐ Change Order
☐ A-30 ☐ 4/5 Vote

FORM APPROVED COUNTY COUNSEL
AS TO LEGAL FORM
4-14-14
Departmental Concurrence

BACKGROUND:

Summary (continued)

The California Mental Health Services Authority (CalMHSA) is a Joint Powers of Authority (JPA) of California Counties focused on the efficient delivery of California Mental Health Projects. Member Counties jointly develop, fund, and implement mental health services, projects, and educational programs at the state, regional, and local levels. CalMHSA is a best practice inter-governmental structure with growing capacity and capability to promote systems and services arising from a shared member commitment to community mental health.

Riverside County became a member on October 14, 2010 to work collectively to administer the MHSA Statewide funds and explore other opportunities for the betterment of California Mental Health Services in concert with other Counties. At CalMHSA's 2012 Strategic Planning Session, members gave staff direction to explore the feasibility of the JPA acting on behalf of member counties in the development of an annual joint purchase agreement with Department of State Hospitals (DSH) for statewide utilization of State Hospital beds (as provided under sections 4330 et seq. of the Welfare Institutions Codes (WIC)), and to consider operationalizing certain functions.

Counties and the California Mental Health Directors Association (CMHDA) have had concerns stemming from how the State has handled state hospital bed management in recent years. DSH has demonstrated a lack of compliance with statutory notice periods, third party reimbursement, incomplete information about the setting of rates, challenges in the access to beds paid for by Counties, overpayment or duplicate payment of bed days, issues of quality of care, concern about indemnification between the State and Counties, and difficulties for County personnel who must conduct oversight on State Hospital grounds. The DSH increased the average daily bed rate by 28% for FY 2011-12 and FY 2012-13. This trend of cost increases cannot be sustained by Counties procuring beds and alternative measures were considered.

The statutes, referred to above, repeatedly refer to counties contracting in combination with other counties. A county JPA, such as CalMHSA, is a viable contracting agency for doing so. Counties acting alone have been unsuccessful. Counties contracting together are more effective in having the State address their concerns.

Sections 4330 through 4335 of the Welfare and Institutions Code provide for Counties, including Counties acting jointly, to contract with the State Department of State Hospitals (DSH) for use of State Hospital facilities for their civil commitments under Division 5 of the California Welfare and Institutions Code. Certain members of CalMHSA desire to authorize CalMHSA to jointly negotiate and contract with the State Department of State Hospitals for use of such facilities on their behalf.

Based on the above, the DMH does hereby enter into this Participation Agreement for the CalMHSA Procurement of State Hospital Beds Program. This Program will subsequently authorize CalMHSA to purchase state hospital beds on behalf of Riverside County and to make payment to the State for such usage consistent with the provisions of this Participation Agreement and the MOU to be entered into by CalMHSA and DSH.

The Participation Agreement for the Procurement of State Hospital Beds outlines the CalMHSA and County's responsibilities as it applies to mental health services in State Hospital facilities. DMH currently contracts for a total of twelve (12) beds in State Hospitals, including Metropolitan State Hospital, Patton State Hospital and Napa State Hospital. Attachment A is a summary of the State Hospital Beds.

The DMH is requesting that the Board of Supervisors ratify this Participation Agreement between DMH and CalMHSA and the MOU between CalMHSA, DMH and the DSH.

Period of Performance
This agreement is effective from July 1, 2013 through June 30, 2014.

Impact on Citizens and Businesses
The State Hospitals provide Continuing Medical Care, Intermediate Care Facility (ICF) – Psychiatric Sub Acute, ICF – Psychiatric, Acute Psychiatric and Acute Specialized Services to citizens/clients of Riverside County whose placements have proven to be clinically inappropriate for lower level of care such as the Institutions of Mental Diseases (IMD), Skilled Nursing Facilities (SNF) or Board and Cares.

SUPPLEMENTAL:
Additional Fiscal Information
Funding for the State Hospital Bed Purchase and Usage agreement is budgeted annually and therefore there are sufficient funds in DMH FY 13/14 budget to provide for the Participation Agreement for the Procurement of State Hospital Beds for FY 13/14. No additional County funds are required.

Contract History and Price Reasonableness
Historically, the Department of Mental Health has always contracted directly with the State Hospitals to provide acute, intermediate and skilled nursing psychiatric services to clients of Riverside County. The bed day rates are set by the Department of State Hospitals.

Justification for Delay
The DMH only recently received the final agreements after a long negotiation between CalMHSA and DSH.

Riverside County
State Hospital Bed Cost Computation
July 1, 2013 through June 30, 2014 (365 Bed Days)

BEDS CONTRACTED BY HOSPITAL

	NAPA	METRO	PATTON	TOTAL
Acute		9		9
Intermediate Care Facility (ICF)				
Skilled Nursing Facility (SNF)		3		3
TOTAL BEDS CONTRACTED		12		12

FY 13/14 SH BED RATE PER/DAY

Acute	$646.00
Intermediate Care Facility (ICF)	$617.00
Skilled Nursing Facility (SNF)	$775.00

TOTAL COST FOR CONTRACTED BEDS

Acute	$2,122,110	$2,122,110
Intermediate Care Facility (ICF)		
Skilled Nursing Facility (SNF)	$848,625	$848,625
TOTAL COUNTY COST	$2,970,735	$2,970,735

OFFICE OF ADMINISTRATION
1600 Ninth Street, Room 150
Sacramento, CA 95814

WHEN DOCUMENT IS FULLY EXECUTED RETURN
CLERK'S COPY
to Riverside County Clerk of the Board, Stop 1010
Post Office Box 1147, Riverside, Ca 92502-1147
Thank you.

Purchase of State Hospital Beds

Memorandum of Understanding

California Department of State Hospitals
and
The California Mental Health Services Authority (CalMHSA) and Participating Counties

I. RECITALS

The parties to this Memorandum of Understanding ("MOU") are the California Department of State Hospitals ("DSH"), the California Mental Health Services Authority ("CalMHSA") as administrative agent for participating Counties, and each participating County which has executed this MOU ("County") as indicated in Exhibit 1. "MOU" shall be deemed to include Exhibits 1-3, attached hereto.

The DSH has jurisdiction over all state hospitals ("Hospitals") which provide services to persons with mental disorders, in accordance with Welfare & Institutions Code (WIC) Section 4100 et seq. All hospitals shall comply with the responsibilities noted for DSH in this agreement. A description of services provided by the DSH shall be included in Exhibit 2.

Sections 4330 of the WIC requires counties to reimburse DSH (formerly, known as the Department of Mental Health) for its use of state hospital ("Hospital") beds and services provided pursuant to the Lanterman-Petris-Short Act ("LPS", WIC Section 5000 et seq.) pursuant to annual contracts between DSH and each county acting singly or in combination with other counties, pursuant to WIC Section 4331.

CalMHSA is a joint powers authority pursuant to Government Code Section 6500, et. seq. (Joint Exercise of Powers Act) of counties and cities with mental health programs, and was requested by its members to negotiate a joint agreement with DSH, and serve as liaison agency for matters of compliance with terms and conditions.

The parties are independent agencies. Nothing herein contained shall be construed as creating the relationship of employer and employee, or principal and agent, between the parties or any of their agents or employees. Notwithstanding the independence of the parties, all patient services must be integrated and coordinated across levels of care for continuity of care.

MAY 06 2014 3-12

On June 13, 2012, the Department of Mental Health, now the DSH, sent a letter to Local Mental Health Directors entitled "State Hospital Rates and Bed Purchase Instructions for Fiscal year 2012-13," which pertains to the County's Hospital rates for bed use. DSH has agreed to maintain the same rates for Fiscal Year 2013-14 as Fiscal Year 2012-2013, which are set forth in Exhibit 3.

II. TERMS AND CONDITIONS

A. The term of this MOU is July 1, 2013 through June 30, 2014

B. County Referred Patients ("Patients")

1. County shall screen, determine the appropriateness of, and authorize all referrals for admission of Patients to the Hospital. County shall, at the time of admission, provide admission authorization and identify the preferred Hospital and bed type to which a Patient is being referred, and identify the estimated length of stay for each Patient. However, Hospital's Medical Director or designee shall make the determination of the appropriateness of a Patient for admission to the preferred Hospital and assign the Patient to the appropriate level of care and treatment unit.

   If Medical Director or designee's assessment determines patient shall not be admitted to the preferred hospital, the preferred hospital will notify the County and DSH – Sacramento for review and consideration of placement within an alternative appropriate DSH facility.

2. County shall name a point of contact and provide assistance to Hospital treatment staff in the screening of Patients to initiate, develop and finalize discharge planning and necessary follow-up services for Patients. Either party may initiate this process.

C. Description of Covered Hospital Services

1. Each county shall provide DSH the total number of the county's bed purchase commitment for each bed type defined by DSH. DSH defines bed types and uses in accordance with the following California Department of Public Health hospital licensing definitions. These definitions shall apply to the MOU:

   Acute Psychiatric Hospital (APH)
   Acute psychiatric hospital means a hospital having a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff which provides 24-hour inpatient care for mentally disordered, incompetent or other patients referred to in Division 5 (commencing with section 5000) or Division 6 (commencing with section 6000) of the Welfare and Institutions Code, including the following basic services: medical, nursing, rehabilitative, pharmacy and dietary services. An acute psychiatric hospital shall not include separate buildings which are used exclusively to house personnel or provide activities not related to hospital patients.

Intermediate Care Facility (ICF)
Intermediate care facility is a health facility, or a distinct part of a hospital or skilled nursing facility which provides inpatient care to patients who have need for skilled nursing supervision and need supportive care, but who do not require continuous nursing care.

Skilled Nursing Facility (SNF)
Skilled nursing facility is a health facility or a distinct part of a hospital which provides continuous skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis. A skilled nursing facility provides 24-hours inpatient care and, as a minimum, includes physician, skilled nursing, dietary, pharmaceutical services and an activity program.

2. As the Hospitals' bed capacity permits, DSH shall provide inpatient psychiatric health care and treatment, including outside medical health care and treatment, ancillary care and treatment, and/or support services, to those Patients referred by the County for LPS services, including those admitted pursuant to Penal Code Section 1370.01 and a Murphy Conservatorship (Welfare and Institution Code Section 5008(h)(1)(B). Summary of Services Provided to LPS Patients and Definition of such care is detailed in Exhibit 2.

3. DSH and County shall provide or cause to be provided expert witness testimony by appropriate mental health professionals in legal proceedings required for the commitment, admission, or treatment of Patients.

4. County is responsible for transportation to and from Hospitals in the following circumstances: court appearances, County-based medical appointments or services, and pre-placement visits and final placements. County is also responsible for transportation between Hospitals when County initiates the transfer. DSH is responsible for all DSH initiated transportation between the Hospitals and transportation to and from local medical appointments or services. The reimbursement rates in Exhibit 3, entitled "State Hospital Cost Computation, July 1, 2012 through June 30, 2013," include reimbursement for transportation.

5. Hospitals shall be culturally competent (including sign-language) in staff and resources to meet the needs of patients treated pursuant to this MOU.

   Multi-disciplinary treatment team composition will be provided as set forth in Exhibit 2.

D. Admission & Discharge Procedures

1. Hospital admissions, intra-hospital transfers, referrals to outside medical care, and discharges shall be in accordance with the admission and discharge criteria established by court order, statute, and DSH. A complete admission package must be submitted with the referral, including all assessments

available.

2. For Penal Code conversions of a patient already in a bed at a State Hospital, these beds shall be separate and apart from the dedicated capacity guaranteed, and shall be billed as excess use as described in II J of this MOU.

3. All denials of admission shall be in writing with an explanation for the denial. Denials shall not occur if the patient meets the admission criteria and the County has dedicated capacity available, or has obtained authorization from another County to use its available dedicated capacity. Denial of admission shall be based on bed capacity and an inability to provide appropriate treatment based on patient specific treatment needs. A denial of admission may be appealed as provided in the next paragraph.

4. Appeal Process for Admissions. When agreement cannot be reached between the County staff and the hospital admitting staff regarding whether a patient meets or does not meet the admission criteria for the bed(s) available, the following appeal process shall be followed. Such appeals may be made immediately by telephone. If the hospital Medical Director and the County Medical Director, or designee, are unable to achieve agreement, the case may be referred to the Hospital Executive Director and the County Mental Health Director within two (2) working days. If the Hospital Executive Director and the County Mental Health Director are unable to achieve agreement, the case may be referred to the DSH Chief Deputy Director within two (2) working days. The Chief Deputy Director shall discuss the case with the DSH Medical Director and may obtain additional consultation from the County Mental Health Director. The Chief Deputy Director shall render a final decision within two (2) working days after receiving the documented basis on which the appeal is based. Appeal resolution for cases involving complex factors may exceed the timelines referenced in section D4.

5. Discharge planning shall begin at admission. A hospital shall discharge a patient at the County's request or in accordance with the approved discharge plan except: (1) if at the time the discharge is to occur, the hospital's Medical Director, or designee, determines that the patient's condition and the circumstances of the discharge would pose an imminent danger to the safety of the patient or others; or, (2) when a duly appointed conservator refuses to approve the patient's discharge or placement. A denial of discharge may be appealed as provided the next paragraph.

6. Appeals of Discharges. When the hospital Medical Director, or designee, determines that discharge cannot occur in accordance with the approved plan or upon the request of County, he/she will contact the County Medical Director or designee immediately to review the case and shall make every effort to resolve the issues preventing the discharge. If this process does not result in agreement, the case may be referred to the hospital Executive Director, by the County Mental Health Director within one (1) working day of the hospital's denial. If this process does not result in agreement, the case may be referred to the DSH Chief Deputy Director within one (1) working day. The Chief Deputy Director shall discuss the case with the DSH Medical Director and may obtain

additional consultation with the County Mental Health Director and others. The Chief Deputy Director shall make the final decision within two (2) working days of receiving the documentation of the basis of the disagreement regarding discharge, and communicate this decision to the County Mental Health Director and the hospital Executive Director. Appeal resolution for cases involving complex factors may exceed the timelines referenced in section D6.

E. Bed Type Transfers

1. If, for any reason, a County patient is in a bed that is inappropriate to that patient's needs, the attending clinician shall develop, in consultation with the Hospital's treatment team and the County (except when the urgency of the patient's situation precludes such consultation) a plan for transfer of the patient to an appropriate unit in accordance with the treatment plan. Such a plan shall be developed and communicated to County within forty-eight (48) hours. County may initiate a treatment team discussion with the attending Hospital clinician at any time County feels that a County patient is in a bed that is inappropriate to the patient's needs or does not accurately reflect the level of care the patient requires (acute, intermediate care, or skilled nursing). DSH will notify counties of hospital intra-bed transfers within three (3) working days.

2. The hospital shall provide the County Point of Contact notice of transfers between bed types within two (2) working days of any such transfer.

3. Bed Types Appeals. When agreement cannot be reached between County staff and hospital staff regarding the type of bed a patient needs, the following appeal process shall be followed. When the County staff feels that an impasse has been reached and further discussions would not be productive, the bed type may be appealed, along with all available data and analysis to the hospital Medical Director and the County Mental Health Director. Such appeals may be made immediately by telephone. If the hospital Medical Director and the County Mental Health Director are unable to achieve agreement, the case may be referred to the Deputy Director of Administration within two (2) working days. The Deputy Director shall discuss the case with the County Mental Health Director and may obtain additional consultation. The Deputy Director shall render a final decision within two (2) working days after receiving the documented basis on which the appeal is based. Appeal resolution for cases involving complex factors may exceed the timelines referenced in section E3.

F. Prior Authorization

1. County shall, prior to admission, provide Hospital with complete medical records on file, Short-Doyle Authorization Form, and all applicable court commitment orders for each Patient. County shall identify an initial projected length of stay which the Hospital shall address in Patient's treatment plan and discharge plan.

G. Coordination of Treatment/Case Management

It is the intent of the Parties to this agreement to be collaborative in all matters and specifically to patient care.

1. County shall develop an operational case management system for Patients, and shall identify a case manager or case management team for each Patient. The case manager shall provide available assessment information on admitted Patients to the Hospital.

2. Hospitals shall provide at least two weeks notification of treatment plan conferences or 90-day reviews. Hospitals shall identify a treatment team member to function as the primary contact for the case manager or the case management team. County shall identify a case manager.

3. County may direct Hospital to discharge Patient to a facility that County determines to be more appropriate to Patient's treatment requirements. In such cases, Hospital shall discharge Patient within two days of the date an alternative placement option is identified and available except if the discharge is contrary to the medical necessity of hospitalization or would pose an imminent danger to the safety of Patient or others, or otherwise required by law.

4. When an agreement cannot be reached between County and DSH on clinical assessment, treatment or patient acuity, the DSH Hospital Medical Director and County Medical Director shall confer to resolve. If a resolution cannot be achieved, the issue will be elevated to the DSH - Sacramento Medical Director for review. If resolution is not achieved, County may direct the Hospital to discharge the patient.

H. Patient's Rights and Confidentiality

1. The parties to this MOU shall comply with The Health Insurance Portability and Accountability Act (HIPAA) and all applicable state laws, regulations, and policies relating to patient's rights and confidentiality.

I. Bed Usage Commitment

1. During the 2013-14 fiscal year, DSH shall provide, within Hospitals, specific numbers of beds dedicated to the care of Patients, including those admitted under the LPS Act, including Murphy Conservatorships (Welfare & Institutions Section 5008(h)(1)(B)), and under PC Section 1370.01. The number and type of beds are specified in the attached Exhibit 3.

2. The term "bed purchase commitment" means that DSH shall utilize a system-wide bed purchase commitment approach within Hospitals to ensure that the number of beds contracted for by County shall be available to County at all times for Patients who are appropriate for the services and Hospitals to which the Patient is being referred.

3. County shall be considered to have exceeded its bed purchase commitment on any given day on which more County Patients are assigned to a Hospital in excess of the County bed purchase commitment. County may use beds in excess of its bed purchase commitment when such use does not result in

denial of access of other counties to their bed purchase commitment. County's use in excess of the base amount provided in Exhibit 3 shall be calculated as provided in Exhibit 3 and Section II J of this MOU.

4. County is required to execute Exhibit 1 to this MOU in order to obtain beds pursuant to a bed purchase commitment or on an excess usage basis. A County that has no bed purchase commitment and has not previously executed Exhibit 1 shall execute Exhibit 1 upon application for admission of a patient from the County, and will be billed for such patient on an excess use basis as described in this MOU. As an alternative to purchasing a bed pursuant to this MOU, a County may purchase a bed from any other County. County shall be financially responsible for its use of Hospital resources resulting from, but not limited to, the conversion of Penal Code commitments to Murphy Conservatorships or other LPS commitments.

5. There shall be no decrease or increase in the number of purchased Hospital beds, unless Exhibit 3 to this MOU is amended by mutual agreement (WIC Section 4331(b)(3)) by the parties hereto.

6. Patients under the care of DSH referred to outside medical facilities will remain the responsibility of DSH unless County initiates discharge, at which time the patient and all costs become the responsibility of the County.

J. Bed Payment

The base amount payable by County to DSH concerning all aspects of this MOU shall be the amount reflected in Exhibit 3. The rates were computed based upon Hospital cost computation using the County Net Rate for 2012-2013, specified in Exhibit 3. This rate shall be calculated as prescribed by Section 4330(c) of the WIC and the rate of reimbursement of WIC Section 4331(b)(4).

DSH shall calculate the total cost of County's actual use in Hospitals for each monthly period. If DSH determines the dollar value of the County's use has exceeded the dollar value of the County's bed purchase commitment during the specific month's period, County will be charged as excess usage. Excess use shall be established when the net dollar value of County's actual use exceeds the base amount specified in this MOU for the month. Any County bed use in excess of the base amount, during the 2013-14 fiscal year, shall be an additional cost to County. Such excess cost shall be invoiced monthly as a cost reimbursement by DSH.

County shall reimburse the DSH with its first payment by _____, 2013 (60 days from signing of MOU) and by the 31st of each month thereafter.

K. Utilization Review – Hospital Operations

1. Hospitals shall have ongoing Utilization review activities which shall address the appropriateness of Hospital admissions and discharges, clinical treatment, length of stay and allocation of Hospital resources to most effectively and efficiently meet patient care needs. Such reviews shall be at a minimum of one time per year and include County participation.

2. County shall take part in the utilization review activities.

L. Records

1. Patient Records

   Hospitals shall maintain adequate medical records on each Patient. These medical records shall include legal status, diagnosis, psychiatric evaluation, medical history, individual treatment plan, records of patient interviews, progress notes, recommended continuing care plan, discharge summary and records of services provided by various professional and paraprofessional personnel in sufficient detail to permit an evaluation of services.

2. Financial Records

   The DSH shall prepare and maintain accurate and complete financial records of Hospital's operating expenses and revenue. Such records shall reflect the actual cost of care and treatment for which payment is claimed, on an accrual basis.

   The DSH shall prepare and maintain accurate and complete financial records of the Hospitals' operating expenses and revenue. Such records shall reflect the actual cost of the type of service for which payment is claimed, on an accrual basis. Additionally, such records shall identify costs attributable to County LPS patients, versus other types of patients to whom the Hospitals provide services. Any apportionment of or distribution of costs, including indirect costs, to or between programs or cost centers of the hospitals shall be documented, and shall be made in accordance with generally accepted accounting principles and applicable laws, regulations and state policies. The patient eligibility determination and any fee charged to and collected from patients, together with a record of all billings rendered and revenues received from any source, on behalf of patients treated pursuant to this MOU, must be reflected in the hospital financial records.

3. Retention of Records

   Hospitals shall retain all financial and Patient records pursuant to State and DSH record retention requirements.

M. Revenue

1. The DSH shall collect revenues from Patients and/or responsible third parties, e.g., Medicare, insurance companies, in accordance with WIC Sections 7275 through 7278, and related laws, regulations, and policies.

N. Inspections and Audits

1. Consistent with confidentiality provisions of WIC Section 5328, any authorized representative of County shall have access to the medical and financial records of DSH for the purpose of conducting any fiscal review or audit during the

period of Hospital's record retention. Hospital shall provide County adequate space to conduct such review or audit. County may at reasonable times inspect or otherwise evaluate services provided in the Hospitals; however County shall not disrupt the regular operations of the Hospitals.

2. County shall not duplicate investigations conducted by other agencies, e.g., State Department of Public Health, County Coroner's Office, and District Attorney's Office. Practitioner specific peer review information and information relating to staff discipline is confidential and shall not be made available for review.

O. Notices

1. Except as otherwise provided herein, all communication concerning this MOU shall be with the MOU Coordinator.

   DSH has designated the following as its MOU Coordinator:

   Christian Jones, Associate Governmental Program Analyst
   Christian.jones@dsh.ca.gov
   (916) 651-8727

   County has designated the following as its MOU coordinator:

   Name: Jerry Wengerd, LCSW

   E-mail: wengerd@rcmhd.org

   Phone: 951-358-4501

2. Hospitals shall notify County by telephone, encrypted email or FAX, and in writing, within twenty-four (24) hours of becoming aware of any occurrence of a serious nature which involves a Patient. Such occurrences shall include, but are not limited to, homicide, suicide, accident, injury, battery, patient abuse, rape, significant loss or damage to patient property, and absence without leave.

3. Hospitals shall notify the County by telephone at the earliest possible time, but not later than five (5) working days after the treatment team determines that a Patient on a PC commitment will likely require continued treatment and supervision under a County LPS commitment after the PC commitment expires. Within ten (10) working days of the date the treatment team's determination that continued treatment and supervision should be recommended to County, Hospitals shall provide written notice to County. The written notice shall include the basis for the Hospital's recommendation and the date on which the PC commitment will expire. The above notices to County shall be given not less than thirty (30) days prior to the expiration of the PC commitment. If Hospital fails to notify County at least thirty (30) days prior to the expiration of the PC commitment, County's financial responsibility shall not commence until thirty (30) days after Hospital's telephone notification. However, if DSH is given less than thirty (30) days to change a Patient's commitment by court order, DSH

shall notify County of this change at the earliest possible time. In the event a court order provides DSH less than thirty (30) days to notify County, County's financial responsibility shall commence on the day after the expiration of the PC commitment.

County shall be responsible for making the decision regarding the establishment of any LPS commitment at the expiration of the PC commitment. County shall notify Hospital, in writing, at least fifteen (15) days prior to the expiration of Patients PC commitment, of its decision regarding the establishment of an LPS commitment and continued hospitalization. If County is given less than fifteen (15) days prior to the expiration of a Patient's PC commitment to make its decision, County shall notify DSH of its decision at the earliest possible time prior to expiration of the Patient's PC commitment.

4. Hospitals shall notify County, of the conversion of a Patient on LPS status to a PC commitment status that results in DSH becoming financially responsible for the placement of Patient and removes Patient from County's dedicated bed capacity. Hospital shall notify County, by telephone at the earliest possible time, but not later than five (5) working days after such conversion. Such telephone notification shall be followed by a written notification to County, which shall be submitted no later than ten (10) working days after Patient's conversion.

III. SPECIAL PROVISIONS

A. This MOU is subject to and is superseded by any restrictions, limitations, or conditions enacted by the Legislature and contained in the Budget Act or any statute or regulations enacted by the Legislature which may affect the provisions, terms, or funding of this MOU. The parties do not intend to amend or waive any statutory provision applicable to the use of state hospital beds by counties pursuant to Part 1 of Division 5 of the Welfare and Institutions Code, unless the subsection to be amended or waived is specifically identified in this MOU with a statement indicating the parties intent to amend or waive the provision as thereinafter described. If statutory or regulatory changes occur during the term of this MOU, the parties may renegotiate the terms of this MOU affected by the statutory or regulatory changes.

B. Should DSH's ability to meet its obligations under the terms of this MOU be substantially impaired due to loss of a Hospital license, damage or malfunction of the Hospital, labor union strikes, or other cause beyond the control of DSH, the parties may negotiate modifications to the terms of this MOU.

C. Mutual Indemnification

1. County shall defend, indemnify and hold Contractor and its agencies, their respective officers, employees and agents, harmless from and against any and all liability, loss, expense, attorneys' fees, or claims for injury or damages arising out of the performance of this Agreement but only in proportion to and to the extent such liability, loss, expense, attorneys' fees, or claims for injury or damages are caused by or result from the negligent or intentional acts or omissions of County,

its officers, agents, or employees.

2. DSH shall defend, indemnify and hold County, its officers, employees and agents, harmless from and against any and all liability, loss, expense, attorneys' fees, or claims for injury or damage arising out of the performance of this Agreement but only in proportion to and to the extent such liability, loss, expense, attorneys' fees, or claims for injury or damages are caused by or result from the negligent or intentional acts or omissions of DSH and/or its agencies, their officers, agents, or employees.

D. The signatories below represent that they have the authority to sign this MOU on behalf of their respective agencies. Execution by a participating County of Exhibit 1 confirms the participating County agrees to the terms of this MOU and Exhibits 1-3. This MOU and its Exhibit 1 may be executed in counterparts.

E. This MOU which includes Exhibits 1-3 comprise the entire agreement and understanding of the parties and supersede any prior agreement or understanding.

F. This MOU which includes Exhibits 1-3 may be amended or modified only by a written amendment signed by the parties.

_____ _____

Wayne Clark, President
CalMHSA — Date

_____ _____

Mark Beckley, Deputy Director of Administration
Department of State Hospitals — Date

EXHIBIT 1

Execution indicates that County is a participating County under the MOU.

Jeff Stone

Signature

MAY 06 2014

Date

Name JEFF STONE Title CHAIRMAN, BOARD OF SUPERVISORS

Riverside County

ATTEST:
KECIA HARPER-IHEM, Clerk
By
DEPUTY

APPROVED COUNTY COUNSEL
4-14-14
STEVA

EXHIBIT 2

LPS SERVICES SUMMARY

Licensure

The Hospitals comply with all applicable federal and state laws, licensing regulations and provide services in accordance with generally accepted practices and standards prevailing in the professional community at the time of treatment. The Hospitals, which are accredited, shall make a good faith effort to remain accredited by the Joint Commission throughout the term of the MOU.

DSH provides the following services to its LPS patients as follows:

Core Treatment Team and Nursing Care

The Hospitals provide Treatment Team services that are the core to a patient's stabilization and recovery. The Treatment Team groups consist of the following individuals: Psychiatrist, Psychologists, Social Workers, Rehabilitation Therapists and Nurses. These teams provide highly structured treatment for mental rehabilitation and re-socialization in preparation for an open treatment setting or community placement.

Treatment Team Ratios		
Treatment Team Member:	ICF Staffing Ratio:	Acute Care Staffing Ratio:
Psychiatrist	1:35	1:15
Psychologist	1:35	1:15
Social Worker	1:35	1:15
Rehabilitation Therapist	1:35	1:15
Registered Nurse	1:35	1:15

The Hospitals provide nursing care according to nursing licensing ratio requirements for state hospitals as follows:

Licensing Compliance Nursing Staff Ratios (Non-Treatment Team)		
Nursing Shift:	ICF Staffing Ratio:	Acute Care Staffing Ratio:
A.M. Shift	1:8	1:6
P.M. Shift	1:8	1:6
NOC Shift	1:16	1:12

The ratios provided above are the current staffing standards employed by the Department of State Hospitals. Each facility may adjust unit ratios as necessary for the continued treatment and safety of patients and staff.

Skilled Nursing Facility services provide advanced medical/nursing care for patients who

require 24-hour nursing care and treatment. Care is provided for male and female patients with multiple medical, as well as psychiatric problems. Many of the patients are wheelchair and bed-bound and many require assistance with feeding and are incontinent.

Additional Treatment Services

Medical Services: Medical Clinics include Neurology, GYN, Ophthalmology, Optometry, Endocrinology, Cardiology, Podiatry, Dental and X-Ray services as well as referral services for Gastro-Intestinal care, Hematology, Nephrology, Surgery and related care for diseases of the liver (e.g., Hepatitis C). Full Acute Medical Care services are provided via contracts with two local community hospitals and at a County Hospital.

Physical, Occupational and Speech Therapy (POST) Department provides physical rehabilitation services to all patients at Napa State Hospital with the goal of assisting patients to reach or maintain their highest level of functioning. The POST Team provides assessment services, treatment services and training to staff and patients on the use and care of adaptive equipment that has been evaluated as appropriate for the patient.

Individualized Active Recovery Services: Active Recovery Services focus on maximizing the functioning of persons with psychiatric disabilities and are provided both within the residential units and in the Treatment Mall. Treatment is geared to identify, support and build upon each person's strengths to achieve their maximum potential in meeting the person's hopes, dreams, treatment needs and life goals.

Active Recovery Services at State Hospital:

- Are based on the specific needs of each individual.
- Are developed and delivered based on a philosophy of recovery.
- Provide a wide range of courses and activities designed to help individuals develop knowledge and skills that support recovery and transition toward community living.
- Are organized to fully utilize staff resources and expertise.
- Provide a range of services that lead to a more normalized environment outside of the residential areas.
- Are facilitated by Psychiatrists, Psychologists, Social Workers, Rehab Therapy staff, and nursing staff.

Industrial Therapy: Opportunities include dining room cleaning services, grounds maintenance as well as other therapeutic services. Participants must demonstrate an appropriate level of behavior to ensure safety and security.

EXHIBIT 3

RIVERSIDE COUNTY
STATE HOSPITAL COST COMPUTATION
July 1, 2013 through June 30, 2014 (365 Days)

1. BEDS REQUESTED BY HOSPITAL

	NAPA	METROPOLITAN	ATASCADERO	PATTON	TOTAL
Acute	0	9	0	0	9
Intermediate Care Facility (ICF)	0	0	0	0	0
Skilled Nursing Facility (SNF)	0	3	0	0	3
Total Beds Requested	0	12	0	0	12

2. STATE HOSPITAL BED RATE FOR FY 2013-14

Acute	$646
Intermediate Care Facility (ICF)	$617
Skilled Nursing Facility (SNF)	$775

3. TOTAL COST FOR CONTRACTED BEDS

Methodology: Multiply to county net rate times 365 to find the annualized cost for the necessary treatment. Multiply the annualized cost times the number of beds requested to find the annual total cost per the necessary treatment.

	NAPA	METROPOLITAN	ATASCADERO	PATTON	TOTAL
Acute	$0	$2,122,110	$0	$0	$2,122,110
Intermediate Care Facility (ICF)	$0	$0	$0	$0	$0
Skilled Nursing Facility (SNF)	$0	$848,625	$0	$0	$848,625
Total County Cost	$0	$2,970,735	$0	$0	$2,970,735

Agreement No. 118-2013-SHB-RC1

CALIFORNIA MENTAL HEALTH SERVICES AUTHORITY
PARTICIPATION AGREEMENT
COVER SHEET

1. Riverside County ("Participant") desires to participate in the Program identified below.

Name of Program: Procurement of State Hospital Beds

2. California Mental Health Services Authority ("CalMHSA") and Participant acknowledge that the Program will be governed by CalMHSA's Joint Powers Agreement and its Bylaws, and by the MOU through which non-Members participate. The following exhibits are intended to clarify how the provisions of those documents will be applied to this particular Program.

☑	Exhibit A	General Program Description
☑	Exhibit B	Scope of Services
☑	Exhibit C	Terms and Conditions
☑	Exhibit D	Budget Detail and Payment Provisions
☐	Exhibit E	Special Terms and Conditions (optional)

3. The term of the Program is 7/1/2013 through 6/30/2017.

4. Authorized Signatures:

CalMHSA

Signed: _____ Name (Printed): John E. Chaquica

Title: Executive Director Date: 2/27/14

Participant

Signed: _____ Name (Printed): JEFF STONE

Title: CHAIRMAN, BOARD OF SUPERVISORS Date: MAY 06 2014

ATTEST:
KECIA HARPER-IHEM, Clerk
By _____ DEPUTY

FORM APPROVED COUNTY COUNSEL
BY: _____ 4-14-14
ELENA M. BOEVA DATE

PARTICIPATION AGREEMENT

Exhibit A – General Program Description

I. Recitals

Government Code section 6500 *et seq.* allows California public entities to form separate entities to exercise powers held by its members. California Counties have under the authority of the Government Code formed the California Mental Health Services Authority (CalMHSA). CalMHSA is authorized by its Joint Exercise of Powers Act to jointly develop, and fund mental health services under, among other things, Division 5 of the California Welfare and Institutions Code, including the provision of necessary administrative services.

Sections 4330 through 4335 of the Welfare and Institutions Code provide for Counties, including Counties acting jointly, to contract with the State Department of State Hospitals for use of State Hospital facilities for their civil commitments under Division 5 of the California Welfare and Institutions Code. Certain members of CalMHSA desire to authorize CalMHSA to jointly negotiate and contract with the State Department of State Hospitals for use of such facilities on their behalf.

Under subdivision (b)(1) of Section 17601 of the Welfare and Institutions Code, Cities and Counties must provide reimbursement to the State for their use of State Hospital beds each month; and under subdivision (b)(2) of Section 17601 of the Welfare and Institutions Code, Cities and Counties may annually elect to have the State Controller withhold funds from their State Hospital and Community Mental Health Allocations in order to reimburse the State Hospitals Account for their use of State Hospital beds, in lieu of making payment themselves. CalMHSA members have made no such election for the current fiscal year, and elect to make payment through CalMHSA.

Based on the foregoing, the parties do hereby enter into this Participation Agreement for the CalMHSA State Hospital Bed Program to authorize CalMHSA to contract for State Hospital beds on behalf of Program Participants and to make payment to the State for such usage consistent with the provisions of this Participation Agreement and the MOU to be entered into by CalMHSA and DSH.

II. Name of Program

The CalMHSA State Hospital Bed Program (SHBP).

III. Program Goals

A. CONTRACTING. In accordance with Welfare and Institutions Code section 4330 et seq., Participants will come together to act jointly through CalMHSA in contracting with the California Department of State Hospitals (DSH) for access and use of state hospital bed resources, and to ensure compliance by DSH with all applicable requirements and provisions of CalMHSA's contract with DSH.

B. FISCAL: Work closely with DSH in the analysis of cost containment strategies that create efficiency in the purchasing of state hospital beds and overall cost.

C. QUALITY OF CARE: Work collaboratively with the DSH in establishing "standardization of services" and consistency in services provided to ensure the quality and levels of patient care needed by counties.
D. ALTERNATIVE OPTIONS FOR SERVICES: Work collectively across counties in the identification and determination of the feasibility of utilizing alternatives to state hospital resources.
E. OTHER OPPORTUNITIES: Evaluate collaborative opportunities in the development of programs for special populations requiring secure 24 hour treatment services (i.e., IMD, court commitments, acute treatment, incompetent to stand trial, etc.).

IV. Program Outcomes

As directed by Participants, CalMHSA will collectively work in achieving efficiencies as a single administrative body engaging in a single negotiation of terms and rates for bed utilization, monitor billing to assure accuracy and fiscal stability, establish quality assurance standards and procedures, review shared financial analysis, and explore opportunities and alternatives.

A. CONTRACTING:

1. Develop new contract terms that address all critical responsibilities, establish performance standards, protect counties from improper inflation of rates, clearly denote bed classification and processes, and require the state to indemnify counties for liability due to the state's negligent acts.
2. Provide counties the ability to audit DSH costs, appeal DSH decisions, and pursue recourse for unfair dealings by DSH.
3. Develop fair and accurate rates.
4. Enable counties to have more control over realignment funds owed to them. (WIC Section Code 17601)
5. Maximize flexibility of bed utilization.

B. FISCAL:

1. Create a baseline to use as a projection of bed use by county and type of bed.
2. Create and maintain an actual cost reimbursement structure. (WIC Section Code 4330)
3. Ensure accuracy of costs charged based on actual use by county and for each bed type.
4. Create a fair and established process for assigning beds.
5. Stabilize and flat line individual county costs.
6. Facilitate an efficient and timely process for invoicing Participants and paying the state.
7. Review excess bed use bills for accuracy.
8. Develop a process for county notification and reconciliation of federal reimbursement for services (Medicare).
9. Begin establishment of a database in order to efficiently evaluate DSH and state hospital services and contract compliance, as well as to evaluate alternatives.
10. Use database to enhance bed rate efficiency by bed type.

C. QUALITY OF CARE SERVICES:

1. Create a baseline for performance measurements and review for compliance.

2. Provide for regular audits/reviews of performance activity of the counties and Hospitals to ensure expectations are being met.
3. Enhance patient care.
4. Reduce bed use and/or length of stay, leading to less cost.
5. Allow CalMHSA to research options for patient services not provided.
6. Ensure standardization across the board and creation of a system to measure against.
7. Track services not provided but needed by counties.
8. Allow counties to be more informed and better served, and for DSH to be more informed, resulting in better service to counties. Enhance processes and outcomes.

D. ALTERNATIVES:

1. Determine what services are needed but not provided by DSH.
2. Evaluate alternative treatment providers.
3. Evaluate alternative treatment resources, allowing counties greater control.

E. OTHER OPPORTUNITIES:

1. Develop a list of challenges in the area of care where a collective solution (two or more counties, regionally, or statewide) could benefit the members.

PARTICIPATION AGREEMENT

Exhibit B – Scope of Services

I. RELATIONSHIP OF THE PARTIES

Sections 4330 through 4335 of the Welfare and Institutions Code (WIC) require counties to contract with DSH to reimburse DSH for use of state hospital beds/services provided pursuant to Part 1 (commencing with Section 5000) of Division 5 of the WIC. Sections 4330 through 4335 of WIC provide for counties to contract in combination with other counties.

The purpose of this Participation Agreement is to grant CalMHSA the authority to contract with DSH for state hospital bed utilization on behalf of Participants, and to define roles and responsibilities between CalMHSA and Participants in the context of an MOU between CalMHSA and DSH.

Demonstrate and provide proof of authorization to enter into this Agreement on behalf of Participant, consisting of a resolution of Participant's Board authorizing such signature, proof of delegated authority to execute contracts of a class that includes this Participation Agreement, or other comparable authority.

II. GOVERNANCE

A. Per CalMHSA Bylaws, CalMHSA members have the authority to create a Program such as the SHSP, while participants in the SHSP govern its operation through adoption and execution of this Participation Agreement.

B. Participants may determine the need for an oversight committee for this program.

III. GENERAL RESPONSIBILITIES OF PARTIES

A. Responsibilities of CalMHSA

1. Comply with applicable laws, regulations, guidelines, CalMHSA's Joint Powers Agreement, Bylaws, this Participation Agreement, and the Program Bylaws.
2. Provide Participants access to state hospital beds purchased by CalMHSA on behalf of Participants.
3. Use best efforts to obtain an appropriate placement for Participants' patients in a state hospital.
4. Facilitate coordination of treatment and case management by DSH and Participant as to each of Participant's patients.
5. Act as fiscal and administrative agent for Participants in the Program in purchasing state hospital beds at state hospitals from DSH for Lanterman-Petris-Short (LPS) hospital services for those patients referred by Participant for treatment at state hospitals, including those admitted pursuant to Sections 1370.01 of the Penal Code (PC), Murphy Conservatorship (Section 5008(h)(1)(B) of the WIC) and those committed pursuant to provisions of the PC which are converted to LPS billing status.
6. Provide dedicated administrative staff as necessary to perform under this Agreement.
7. Manage funds received through the Program, consistent with the requirements of any applicable laws, regulations, guidelines and/or contractual obligations.

8. Provide regular fiscal and operational reports to Participants and any other public agencies with a right to such reports.
9. Develop allocation model for allocation of beds, funds and expenses among Participants.
10. Facilitate operation of Participant focus groups, training, bed triage process, and dispute resolution process.
11. Credit to account of Participant any financial credits, penalties, payments, offsets, or other receipt of funds attributable to Participants' patient.

B. Responsibilities of Participant

1. Compliance with applicable laws, regulations, guidelines, contractual agreements, joint powers agreements and bylaws.
2. Timely payment, assignment, or other transfer of funds assessed for the Program, consisting of payments toward the pre-payment fund, payments for beds, and any necessary administrative and management costs.
3. Designate CalMHSA as Participant's agent in contracting with DSH for purchase of beds at State Hospitals on behalf of Participant pursuant to WIC 4330 through 4335.
4. Identification of a representative authorized to act for Participant and receive notices on behalf of Participant.
5. Provide input and feedback as necessary to accomplish the purposes of the Program.
6. Timely and complete submission of information in response to requests.
7. Acknowledgement that certain funds contributed by the Participant will be aggregated with the funds of other Participants in the Program, and jointly used to meet the objectives of the Program, pursuant to the allocation formula adopted. Acknowledge that Program expenses will include a proportionate share of CalMHSA's administrative expenses and management costs.
8. Agree to pay for bed/days, and for associated administrative and management costs for Participant's patients upon adoption and approval by the Participants of a budget for administrative costs.

III. SERVICES TO BE CONTRACTED WITH DEPARTMENT OF STATE HOSPITALS AS DETAILED IN THE MOU WITH DSH.

IV. BED USAGE

A. Contracting and Bed Tiers

Based on the contractual commitments made by Participants, through this agreement CalMHSA will contract (MOU) with DSH to provide, within the state hospitals, specific numbers of beds dedicated to the care of those patients referred by CalMHSA Participants, including those admitted pursuant to Section 1370.01 of the Penal Code and Murphy Conservatorships (WIC § 5008(h)(1)(B)) (i.e., Participants' patients).

The number and type of beds for which Participant is committed under this Participation Agreement are specified in Exhibit B of the MOU with DSH. This may include the following tiers of beds.

a. Beds for which individual Participants have committed (Tier I).
b. Aggregated beds for foreseeable excess use (Tier II).
c. Additional bed/days procured from DSH with Participant authorization (Tier III).

For the purposes of this Participation Agreement the term "committed beds" shall mean that CalMHSA has contracted with DSH to ensure that the number of beds contracted for in a particular cost center category shall be available to Participant at all times for Participant's patients who are appropriate for the services and facilities included in that cost center at the hospital to which the patient is being referred. These shall be Tier I beds.

Tier 1 Beds

Tier I Beds are those bed/types for which a Participant specifically commits, analogous to the commitments made in prior contracts between counties and the California Department of Mental Health (now DSH).

Tier II Beds

Tier II Beds are those bed/types for which CalMHSA contracts with DSH on behalf of those Participants interested in accessing such an aggregate pool. The number of beds contracted for will be calculated based on estimated potential use and each participating Participant billed monthly along with Tier I billing. The calculated amount will be reconciled by CalMHSA with actual usage annually or more often, such that each Participant will only pay for actual usage. Reconciliation would occur within 60 days of the end of the fiscal year and an adjustment will appear in the September billing.

Tier II Beds

Tier III Beds describes a pre-funding mechanism for those Participants who are interested in such pre-funding, the amount of which will be calculated based on estimated or projected use of bed/days in excess of Tiers I and II. The pre-fund calculation will be provided to Participants by June 1 annually, with interested Participants contributing by July 31 each year. Tier III expenditures will be reconciled at the end of each fiscal year.

B. Exceeding Contracted Capacity

Participant shall be considered to have exceeded its committed capacity on any given day on which more Participant patients are assigned to a cost center than the Participant has contracted for Tier 1 beds or available in Tier II beds on a pooling basis. Participant shall be permitted to use beds in excess of Tier I and Tier II capacity when use does not result in denial of access of other counties to their dedicated capacity. CalMHSA shall attempt to obtain placement for Participant's patients on an excess basis within one week of notice. Participant's use in

excess of the Participation Agreement amount shall be calculated as provided in Exhibit B of the DSH MOU.

CalMHSA shall review Participant's use of state hospital beds on a monthly basis to determine if the dollar value of Participant's use has exceeded the dollar value of Participant's contracted beds under this Participation Agreement. Excess use shall be established when the net dollar value of Participant's actual use exceeds the contracted amount for the period under consideration. Participant shall be obligated to pay the contract amount for the period or the dollar value of Participant's actual use for the period, whichever is greater.

C. Participant's Financial Commitment

So that no Participant shall be obligated beyond its commitment, no one Participant's maximum obligation shall be reduced below the contract amount set forth in Exhibit B of the DSH MOU.

A Participant that has not committed to any state hospital bed/years shall be financially responsible for its use of state hospital resources resulting from, but not limited to, the conversion of Penal Code commitments to Murphy Conservatorships (WIC § 5008(h)(1)(8)).

There shall be no decrease in the number of beds contracted for by Participant within the state hospitals and within a cost center, unless this Participation Agreement is amended by mutual agreement not later than January 1 of the fiscal year. (WIC § 4331(b)(3).)

When Participant has a patient at a hospital other than at its primary use LPS hospital, CalMHSA shall use one of Participant's vacant dedicated beds, in an equivalent cost center at its primary use LPS hospital, to cover the costs of that patient's care. If Participant has no available dedicated capacity, it shall obtain the required capacity by purchasing it from CalMHSA or directly from DSH.

PARTICIPATION AGREEMENT

Exhibit C - General Terms and Conditions

I. Definitions

Throughout this Participation Agreement, the following terms are defined as follows:

A. CalMHSA - California Mental Health Services Authority, a Joint Powers Authority created to jointly develop and fund mental health services and education programs for its Member Counties and Partner Counties.

B. Department of Health Care Services (DHCS) - The California Department of Health Care Services.

C. Department of State Hospitals (DSH) – The California Department of State Hospitals

D. Member – refers to a County (or JPA of two or more Counties) that has joined CalMHSA and executed the CalMHSA Joint Powers Agreement.

E. Mental Health Services Act (MHSA) – Initially known as Proposition 63 in the November 2004 election, which added sections to the Welfare and Institutions Code providing for, among other things, PEI Programs.

F. Mental Health Services Oversight and Accountability Commission (OAC) - The oversight body to ensure the activities are in accordance with the Mental Health Services Act.

G. Partner - A non-Member County (or multi-county JPA) participating in a Program with CalMHSA Members.

H. Participant– Counties participating in the Program either as Members of CalMHSA or as Partners under a Memorandum of Understanding with CalMHSA.

I. Program – The program identified in the Cover Sheet.

II. Responsibilities

A. Responsibilities of CalMHSA:

1. Develop Program plan, updates, and/or work plans as necessary on behalf of and in coordination with Participants that are consistent with applicable laws, regulations, guidelines and/or contractual obligations. These may include, but are not limited to, obligations imposed by DHCS and/or OAC.

2. Act as fiscal and administrative agent for Participants in the Program.

3. Directly or indirectly (through a contracted JPA Management firm) hire and employ Program Directors and other administrative staff as necessary to perform under this Participation Agreement.

4. Submission of plans, updates, and/or work plans on behalf of and/or in coordination with Participants for review and approval by any public agency with authority over the Program.

5. Management of funds received the Program consistent with the requirements of any applicable laws, regulations, guidelines and/or contractual obligations.

6. Provide regular fiscal reports to Participants and/or other public agencies with a right to such reports.

7. Develop allocation model for allocation of funds and expenses among Participants, years, and Programs.

8. Compliance with CalMHSA's Joint Powers Agreement and Bylaws.

C. Responsibilities of Participants:

1. Timely assignment of funds assessed for the Participating Program.

2. Identification of a representative authorized to act for Participant and receive notices on behalf of Participant. Identification of an alternate to attend meetings in absence of representative.

3. Attend advisory committee meetings for the Program, and provide input as necessary to accomplish the purposes of the Program.

4. Cooperate by providing CalMHSA with requested information and assistance in order to fulfill the purpose of the Program.

5. Provide feedback on Program performance.

6. Timely and complete submission in response to requests for information and items needed.

7. Acknowledgement that funds contributed by the Participant will be pooled with the funds of other Participants in the Program, and jointly used to meet the objectives of the Program, pursuant to the allocation formula adopted for the Program. Program expenses will normally include a proportionate share of CalMHSA's general administrative expenses, since there is no independent source of funding for such expenses.

8. Compliance with applicable laws, regulations, guidelines, contractual agreements, joint powers agreements and bylaws.

III. Duration and Term

A. The term of the Program is as shown on the Cover Sheet.

B. Any Participant may withdraw from the Program upon six months written notice. Notice shall be deemed served on the date of mailing.

C. The majority of the Participants may vote to expel a Participant from the Program for cause. Cause shall be defined as any breach of this Participation Agreement, any misrepresentation, or fraud on the part of any Participant.

IV. Withdrawal, Cancellation and Termination

A. The withdrawal of a Participant from the Program shall not automatically terminate its responsibility for its share of the expenses and liabilities of the Program. The contributions of current and past Participants are chargeable for their respective share of unavoidable expenses and liabilities arising during the period of their participation

B. Upon cancellation, termination or other conclusion of the Program, any funds remaining undisbursed after CalMHSA satisfies all obligations arising from the operation of the Program shall be distributed and apportioned among the Participants in proportion to their contributions.

V. Fiscal Provisions

A. Funding required from the Participants will not exceed the amount stated in the Cover Sheet.

B. Participants will share in the costs of planning, administration and evaluation in the same proportions as their overall contributions, which are included in the amount stated on the Cover Sheet.

PARTICIPATION AGREEMENT

EXHIBIT D - BUDGET DETAIL AND PAYMENT PROVISIONS

STATE HOSPITAL BED PURCHASE AND USAGE

I. CONTRACT AMOUNT AND PAYMENT PROVISIONS

The amount payable by Participant to CalMHSA concerning this Agreement shall be $26,638 per fiscal year. The amount for operations does not include the financial obligation of the Participant for actual bed use. The amount reflected here was computed based on the information contained in the Exhibit B of the DSH MOU. The amount represents the application of the State Hospital Rates for the Fiscal Year as published by DSH, which by this reference is made a part hereof, to Participant's contracted beds. In addition, this amount includes an administrative charge assessed on the number of contracted beds listed in Exhibit B of the DSH MOU, based the SHSP administrative budget adopted for the fiscal year by the Participants.

Any Participant bed use in excess of the contracted amount, as defined in Exhibit B of the DSH MOU, during the fiscal year, shall be an additional financial obligation to Participant.

Prepayment and funding process will be electronic with a completed form attached. All submissions shall be reviewed by the Bed Pool Manager (BPM).

Tier I Beds

Participant shall provide to CalMHSA the number of beds they want to obligate to by December 31st, six months prior to end of the fiscal year. CalMHSA shall make the necessary computation based on the obligation of December 31st by bed type and rate to determine the Participants obligation amount.

Upon determination, notice will be sent to the Participant, annually by June 1st. Participants shall pay CalMHSA by the 15th of each month commencing July 15th.

Tier II Beds

CalMHSA will make computations for the projected aggregated obligation, based on historical use. This total shall be reduced by Tier I beds and adjusted for potential decrease in use. This computation will added to the MOU with DSH, along with Tier I computation.

Computation will be reconciled (obligation vs. used) annually such that Participant will only pay for actual use. This is to be provided within 60 days of each year-end and any adjustments shall be provided in the September invoice.

Tier III Beds

CalMHSA shall be the point agency to procure excess beds not obligated by the Participant or CalMHSA (i.e. Tier I or II Beds). A pre-fund computation will be established and provided to Participant by June 1st annually. Participant shall contribute to this pre-fund by July 31st annually. This obligation will be reconciled a year-end for the subsequent years Pre-Fund.

DSH shall invoice CalMHSA monthly for actual bed use. CalMHSA will make the computation of actual use for the Participant, for that month. A single invoice shall be issued to the Participant with reimbursement to CalMHSA within 30 days. CalMHSA shall make payment to DSH in accordance with the MOU.

II. BUDGET CONTINGENCIES

This Participation Agreement is subject to any restrictions, limitations, or conditions enacted by the Legislature and contained in the Budget Act or any statute enacted by the Legislature which may affect the provisions, terms, or funding of this Participation Agreement in any manner. If statutory or regulatory changes occur during the term of this Participation Agreement, both parties may renegotiate the terms of the Participation Agreement affected by the statutory or regulatory changes.

This Participation Agreement may be amended only in writing upon mutual consent of the parties. A duly authorized representative of each party shall execute such amendments.

Riverside County Board of Supervisors
Request to Speak

Submit request to Clerk of Board (right of podium), Speakers are entitled to three (3) minutes, subject to Board Rules listed on the reverse side of this form.

SPEAKER'S NAME: Holmstrom, Bruce

Address: _____
(only if follow-up mail response requested)

City: _____ **Zip:** _____

Phone #: _____

Date: _____ **Agenda #** 3-12 MH

PLEASE STATE YOUR POSITION BELOW:

Position on "Regular" (non-appealed) Agenda Item:

_____**Support** _____**Oppose** _____**Neutral**

Note: If you are here for an agenda item that is filed for "Appeal", please state separately your position on the appeal below:

_____**Support** _____**Oppose** _____**Neutral**

I give my 3 minutes to: _____

BOARD RULES

Requests to Address Board on "Agenda" Items:

You may request to be heard on a published agenda item. Requests to be heard must be submitted to the Clerk of the Board before the scheduled meeting time.

Requests to Address Board on items that are "NOT" on the Agenda:

Notwithstanding any other provisions of these rules, member of the public shall have the right to address the Board during the mid-morning "Oral Communications" segment of the published agenda. Said purpose for address must pertain to issues which are under the direct jurisdiction of the Board of Supervisors. YOUR TIME WILL BE LIMITED TO THREE (3) MINUTES.

Power Point Presentations/Printed Material:

Speakers who intend to conduct a formalized Power Point presentation or provide printed material must notify the Clerk of the Board's Office by 12 noon on the Monday preceding the Tuesday Board meeting, insuring that the Clerk's Office has sufficient copies of all printed materials and at least one (1) copy of the Power Point CD. Copies of printed material given to the Clerk (by Monday noon deadline) will be provided to each Supervisor. If you have the need to use the overhead "Elmo" projector at the Board meeting, please insure your material is clear and with proper contrast, notifying the Clerk well ahead of the meeting, of your intent to use the Elmo.

Individual Speaker Limits:

Individual speakers are limited to a maximum of three (3) minutes. Please step up to the podium when the Chairman calls your name and begin speaking immediately. Pull the microphone to your mouth so that the Board, audience, and audio recording system hear you clearly. Once you start speaking, the "green" podium light will light. The "yellow" light will come on when you have one (1) minute remaining. When you have 30 seconds remaining, the "yellow" light will begin flash, indicating you must quickly wrap up your comments. Your time is up when the "red" light flashes. The Chairman adheres to a strict three (3) minutes per speaker. ***Note: If you intend to give your time to a "Group/Organized Presentation", please state so clearly at the very bottom of the reverse side of this form.***

Group/Organized Presentations:

Group/organized presentations with more than one (1) speaker will be limited to nine (9) minutes at the Chairman's discretion. The organizer of the presentation will automatically receive the first three (3) minutes, with the remaining six (6) minutes relinquished by other speakers, as requested by them on a completed "Request to Speak" form, and clearly indicated at the front bottom of the form.

Addressing the Board & Acknowledgement by Chairman:

The Chairman will determine what order the speakers will address the Board, and will call on all speakers in pairs. The first speaker should immediately step to the podium and begin addressing the Board. The second speaker should take up a position in one of the chamber aisles in order to quickly step up to the podium after the preceding speaker. This is to afford an efficient and timely Board meeting, giving all attendees the opportunity to make their case. Speakers are prohibited from making personal attacks, and/or using coarse, crude, profane or vulgar language while speaking to the Board members, staff, the general public and/or meeting participants. Such behavior, at the discretion of the Board Chairman may result in removal from the Board Chambers by Sheriff Deputies.