

INTERGOVERNMENTAL AGREEMENT REGARDING TRANSFER OF PUBLIC FUNDS

This Agreement is entered into between the CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES ("DHCS") and the COUNTY OF MENDOCINO (GOVERNMENTAL FUNDING ENTITY) with respect to the matters set forth below.

The parties agree as follows:

AGREEMENT

1. Transfer of Public Funds

1.1 The GOVERNMENTAL FUNDING ENTITY agrees to make a transfer of funds to DHCS pursuant to sections 14164 and 14301.4 of the Welfare and Institutions Code. The amount transferred shall be based on the sum of the applicable rate category per member per month (PMPM) contribution increments multiplied by member months, as reflected in Exhibit 1. The GOVERNMENTAL FUNDING ENTITY agrees to initially transfer amounts that are calculated using the Estimated Member Months in Exhibit 1, which will be reconciled to actual enrollment for the service period of July 1, 2018 through June 30, 2019 in accordance with Sub-Section 1.3 of this Agreement. The funds transferred shall be used as described in Sub-Section 2.2 of this Agreement. The funds shall be transferred in accordance with the terms and conditions, including schedule and amount, established by DHCS.

1.2 The GOVERNMENTAL FUNDING ENTITY shall certify that the funds transferred qualify for Federal Financial Participation pursuant to 42 C.F.R. part 433, subpart B, and are not derived from impermissible sources such as recycled Medicaid payments, Federal money excluded from use as State match, impermissible taxes, and non-bona fide provider-

related donations. Impermissible sources do not include patient care or other revenue received from programs such as Medicare or Medicaid to the extent that the program revenue is not obligated to the State as the source of funding.

1.3 DHCS shall reconcile the "Estimated Member Months," in Exhibit 1, to actual enrollment in HEALTH PLAN(S) for the service period of July 1, 2018 through June 30, 2019 using actual enrollment figures taken from DHCS records. Enrollment reconciliation will occur on an ongoing basis as updated enrollment figures become available. Actual enrollment figures will be considered final two years after June 30, 2019. If this reconciliation results in an increase to the total amount necessary to fund the nonfederal share of the payments described in Sub-Section 2.2, the GOVERNMENTAL FUNDING ENTITY agrees to transfer any additional funds necessary to cover the difference. If this reconciliation results in a decrease to the total amount necessary to fund the nonfederal share of the payments described in Sub-Section 2.2, DHCS agrees to return the unexpended funds to the GOVERNMENTAL FUNDING ENTITY. If DHCS and the GOVERNMENTAL FUNDING ENTITY mutually agree, amounts due to or owed by the GOVERNMENTAL FUNDING ENTITY may be offset against future transfers.

2. Acceptance and Use of Transferred Funds

2.1 DHCS shall exercise its authority under section 14164 of the Welfare and Institutions Code to accept funds transferred by the GOVERNMENTAL FUNDING ENTITY pursuant to this Agreement as IGTs, to use for the purpose set forth in Sub-Section 2.2.

2.2 The funds transferred by the GOVERNMENTAL FUNDING ENTITY pursuant to Section 1 and Exhibit 1 of this Agreement shall be used to fund the non-federal share of Medi-Cal Managed Care actuarially sound capitation rates described in section 14301.4(b)(4) of the Welfare and Institutions Code as reflected in the contribution PMPM and rate categories

reflected in Exhibit 1. The funds transferred shall be paid, together with the related Federal Financial Participation, by DHCS to HEALTH PLAN(S) as part of HEALTH PLAN(S)' capitation rates for the service period of July 1, 2018 through June 30, 2019, in accordance with section 14301.4 of the Welfare and Institutions Code.

2.3 DHCS shall seek Federal Financial Participation for the capitation rates specified in Sub-Section 2.2 to the full extent permitted by federal law.

2.4 The parties acknowledge that DHCS will obtain any necessary approvals from the Centers for Medicare and Medicaid Services.

2.5 DHCS shall not direct HEALTH PLAN(S)' expenditure of the payments received pursuant to Sub-Section 2.2.

3. Assessment Fee

3.1 DHCS shall exercise its authority under section 14301.4 of the Welfare and Institutions Code to assess a 20 percent fee related to the amounts transferred pursuant to Section 1 of this Agreement, except as provided in Sub-Section 3.2. GOVERNMENTAL FUNDING ENTITY agrees to pay the full amount of that assessment in addition to the funds transferred pursuant to Section 1 of this Agreement.

3.2 The 20-percent assessment fee shall not be applied to any portion of funds transferred pursuant to Section 1 that are exempt in accordance with sections 14301.4(d) or 14301.5(b)(4) of the Welfare and Institutions Code. DHCS shall have sole discretion to determine the amount of the funds transferred pursuant to Section 1 that will not be subject to a 20 percent fee. DHCS has determined that \$0.00 of the transfer amounts, will not be assessed a 20 percent fee, subject to Sub-Section 3.3.

3.3 The 20-percent assessment fee pursuant to this Agreement is non-refundable and shall be wired to DHCS separately from, and simultaneous to, the transfer amounts made under Section 1 of this Agreement. If, at the time of the reconciliation performed pursuant to Sub-Section 1.3 of this Agreement, there is a change in the amount transferred that is subject to the 20-percent assessment in accordance with Sub-Section 3.1, then a proportional adjustment to the assessment fee will be made.

4. Amendments

4.1 No amendment or modification to this Agreement shall be binding on either party unless made in writing and executed by both parties.

4.2 The parties shall negotiate in good faith to amend this Agreement as necessary and appropriate to implement the requirements set forth in Section 2 of this Agreement.

5. Notices. Any and all notices required, permitted or desired to be given hereunder by one party to the other shall be in writing and shall be delivered to the other party personally or by United States First Class, Certified or Registered mail with postage prepaid, addressed to the other party at the address set forth below:

To the GOVERNMENTAL FUNDING ENTITY:

Tammy Moss Chandler, Director
Health & Human Services Agency
Mendocino County
747 South State Street
Ukiah, CA 95482
chandlert@mendocinocounty.org

With copies to:

Mary Alice Willeford, Administrative Services Manager II
Mendocino County
1120 South Dora Street
Ukiah, CA 95482
willefom@mendocinocounty.org

To DHCS:

Sandra Dixon
California Department of Health Care Services
Capitated Rates Development Division
1501 Capitol Ave., Suite 71-4002
MS 4413
Sacramento, CA 95814
Sandra.Dixon@dhcs.ca.gov

6. Other Provisions

6.1 This Agreement contains the entire Agreement between the parties with respect to the Medi-Cal payments described in Sub-Section 2.2 of this Agreement that are funded by the GOVERNMENTAL FUNDING ENTITY, and supersedes any previous or contemporaneous oral or written proposals, statements, discussions, negotiations or other agreements between the GOVERNMENTAL FUNDING ENTITY and DHCS relating to the subject matter of this Agreement. This Agreement is not, however, intended to be the sole agreement between the parties on matters relating to the funding and administration of the Medi-Cal program. This Agreement shall not modify the terms of any other agreement, existing or entered into in the future, between the parties.

6.2 The non-enforcement or other waiver of any provision of this Agreement shall not be construed as a continuing waiver or as a waiver of any other provision of this Agreement.

6.3 Sections 2 and 3 of this Agreement shall survive the expiration or termination of this Agreement.

6.4 Nothing in this Agreement is intended to confer any rights or remedies on any third party, including, without limitation, any provider(s) or groups of providers, or any right to medical services for any individual(s) or groups of individuals. Accordingly, there shall be no third party beneficiary of this Agreement.

6.5 Time is of the essence in this Agreement.

6.6 Each party hereby represents that the person(s) executing this Agreement on its behalf is duly authorized to do so.

7. State Authority. Except as expressly provided herein, nothing in this Agreement shall be construed to limit, restrict, or modify the DHCS' powers, authorities, and duties under Federal and State law and regulations.

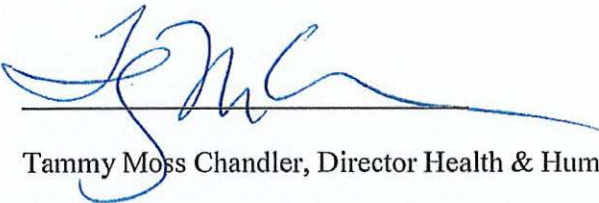
8. Approval. This Agreement is of no force and effect until signed by the parties.

9. Term. This Agreement shall be effective as of July 1, 2018 and shall expire as of December 31, 2021 unless terminated earlier by mutual agreement of the parties.

SIGNATURES

IN WITNESS WHEREOF, the parties hereto have executed this Agreement, on
the date of the last signature below.

THE COUNTY OF MENDOCINO:

By:  Date: 6/9/19
Tammy Moss Chandler, Director Health & Human Services Agency

THE STATE OF CALIFORNIA, DEPARTMENT OF HEALTH CARE SERVICES:


By:  Date: 11/13/19
Jennifer Lopez, Division Chief, Capitated Rates Development Division

Exhibit 1

Funding Entity:	County of Mendocino		
Health Plan:	Partnership Health Plan		
Rating Region:	Northern Region		
Rate Category	Contribution PMPM	Estimated Member Months	Estimated Contribution (Non-Federal Share)
Child - non MCHIP	\$ 0.16	1,053,493	\$ 168,559
Child - MCHIP	\$ 0.04	439,588	\$ 17,584
Adult - non MCHIP	\$ 0.59	563,208	\$ 332,293
Adult - MCHIP	\$ 0.14	11,019	\$ 1,543
SPD	\$ 1.77	296,959	\$ 525,617
SPD/Full-Dual	\$ 0.30	468,766	\$ 140,630
BCCTP	\$ 2.43	2,387	\$ 5,800
LTC	\$ 6.62	655	\$ 4,336
LTC/Full-Dual	\$ 5.42	24,163	\$ 130,963
Whole Child Model	\$ 4.15	28,034	\$ 116,341
Optional Expansion	\$ 0.08	1,185,175	\$ 94,814
Estimated Total		4,073,447	\$ 1,538,480

IN WITNESS WHEREOF

DEPARTMENT FISCAL REVIEW:

By: Tammy Moss Chandler
Tammy Moss Chandler, HHSA Director

Date: 6/19/19

Budgeted: ☒ Yes ☐ No

Budget Unit: 4071

Line Item: 86-2239

Org/Object Code: IG

Grant: ☐ Yes ☒ No

Grant No.:

CONTRACTOR/COMPANY NAME

By: Jennifer Lopez
Jennifer Lopez, Division Chief, Capitated Rates Development Division

Date: _____

NAME AND ADDRESS OF CONTRACTOR:

Sandra Dixon
Capitated Rates Development Division
California Department of Health Care Services
1501 Capitol Avenue, Suite 71-4002, MS 4413
Sacramento, CA 95814

COUNTY OF MENDOCINO

By: Carre Brown
CARRE BROWN, Chair
BOARD OF SUPERVISORS

Date: JUL 24 2019

ATTEST:

CARMEL J. ANGELO, Clerk of said Board

By: Karla Vantaghen
Deputy JUL 24 2019

I hereby certify that according to the provisions of Government Code section 25103, delivery of this document has been made.

CARMEL J. ANGELO, Clerk of said Board

By: Karla Vantaghen
Deputy JUL 24 2019

INSURANCE REVIEW:

By: Chad G. Bello
Risk Management

Date: 6/28/19

COUNTY COUNSEL REVIEW:

APPROVED AS TO FORM:

KATHARINE L. ELLIOTT,
County Counsel

By: Chad G. Bello
Deputy

Date: 6/25/2019

EXECUTIVE OFFICE/FISCAL REVIEW:

By: Darcie Antle
Deputy CEO

Date: 6/28/19

Signatory Authority: \$0-25,000 Department; \$25,001- 50,000 Purchasing Agent; \$50,001+ Board of Supervisors

Exception to Bid Process Required/Completed ☐ N/A

Mendocino County Business License: Valid ☐

Exempt Pursuant to MCC Section: _____