AGREEMENT FOR SERVICES #108-095A-P-E2010
Sierra Foothills AIDS Foundation providing care to persons living with HIV/AIDS under the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act

THIS AGREEMENT made and entered into by and between the County of El Dorado, a political subdivision of the State of California (hereinafter referred to as COUNTY) and Sierra Foothills AIDS Foundation, Inc., a California non-profit public benefit corporation qualified as a tax exempt organization under Title 26 Code of Federal Regulations Section 1.501 (c) (3) commonly referred to as Section 501 (c) (3) of the Internal Revenue Code of 1986, whose principal place of business is 12183 Locksley, #205, Auburn, CA 95603 (hereinafter referred to as CONTRACTOR);

RECITALS

WHEREAS, COUNTY has determined that it is necessary to obtain a Contractor to provide case management services for individuals and families in the County of El Dorado who are living with human immunodeficiency virus (HIV) / Acquired Immunodeficiency Syndrome (AIDS) under Title I of the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act; and

WHEREAS, CONTRACTOR has represented to COUNTY that it is specially trained, experienced, expert and competent to perform the special services required hereunder and COUNTY has determined to rely upon such representations; and

WHEREAS, it is the intent of the parties hereto that such services be in conformity with all applicable Federal, State and local laws; and

WHEREAS, COUNTY has determined that the provision of these services provided by CONTRACTOR is in the public's best interest, and that these services are more economically and feasibly performed by outside independent Contractors as well as authorized by County of El Dorado Charter, Section 210 (b) (6) and/or Government Code 31000;

NOW, THEREFORE, COUNTY and CONTRACTOR mutually agree as follows:

Article I. DEFINITIONS

AIDS	Acquired Immunodeficiency Syndrome.
CARE Act	Ryan White Comprehensive AIDS Resources Emergency Act.
CARE Act Program	The program and activities identified as being funded by Public Law 101-381, the Ryan White Comprehensive AIDS Resources Emergency Act.
CARE PLAN	A comprehensive individualized Care Plan that prioritizes client needs identifies resources to meet those needs and documents mutually agreed-upon goals. This is developed during the initial intake process by the CONTRACTOR during a face-to-face interview with the client.
CCR	California Code of Regulations.
CFR	Code of Federal Regulations.
Client	Those persons who meet the eligibility criteria for the CARE Act Program.
CONTRACTOR	Sierra Foothills AIDS Foundation, Inc.
COUNTY	County of El Dorado.
Contract Administrator	For the purpose of this Agreement, the Contract Administrator shall be that Officer or employee with responsibility for administering this Agreement, pursuant to Article XXI.
DHHS	Sacramento County Department of Health and Human Services
Fiscal Agent	For purposes of this Agreement, the Fiscal Agent shall be the Sacramento County EMA.
GAS	Governmental Audit Standards as described in the General Accounting Office.
HAART Therapy	Highly Active Antiretroviral Therapy
HIV	Human immunodeficiency virus.
HIV Health Services Planning Council	A 30 member community planning body whose primary responsibilities include: assessing the needs of people living with HIV in El Dorado, Placer, Yolo and Sacramento Counties; establishing appropriate service priorities; and allocating approximately $3.5 million in Federal grant funding (as provided under Part A and B of the Ryan White HIV/AIDS Treatment Modernization Act) to pay for the delivery of HIV/AIDS medical and support services for those who otherwise could not afford such services.
HRSA	Health Resources and Services Administration - HRSA is the primary Federal agency for improving access to healthcare services for people who are uninsured, isolated, or medically vulnerable.
PHS	Public Health Services.
PLWH/A	Persons living with HIV/AIDS.
Sacramento EMA	Sacramento Eligible Metropolitan Area.
Sacramento TGA	Sacramento Transitional Grant Area – for purposes of this Agreement, the TGA encompasses Sacramento, El Dorado and Placer counties.

USO	Units of Service as defined in Exhibit A – Attachment 2, attached hereto and incorporated by reference herein.
W&I Code	California Welfare and Institutions Code.

Article II. SCOPE OF SERVICES

CONTRACTOR agrees to provide ambulatory/outpatient medical care to people living with HIV/AIDS. CONTRACTOR will provide comprehensive high quality, client-centered, timely and cost-effective outpatient primary medical services to HIV positive persons at all stages of disease. Services will be provided to HIV positive persons residing in the Sacramento Transitional Grant Area (TGA) which encompasses Sacramento, El Dorado and Placer Counties, who meet the requirements listed and referred to in Exhibit A – Sierra Foothills AIDS Foundation - CARE Act Program, Scope of Services attached hereto and incorporated by reference herein.

Article III. TERM

This Agreement shall become effective upon final execution by both parties hereto and shall cover the period of March 1, 2010 to February 28, 2011 unless earlier terminated pursuant to the provisions under Article XI herein.

Article IV. COMPENSATION FOR SERVICES

Not-to-exceed for services provided pursuant to this Agreement	$141,773
Sierra Foothills AIDS Foundation Administrative Fee (5%)	7,876
Total Not-to-Exceed Amount	$149,649

Adjustments between line items in Exhibit C – Budget & Budget Narrative attached hereto and incorporated by reference herein shall be allowed when agreed to in writing between COUNTY Contract Administrator and CONTRACTOR.

Payment for services rendered shall be in arrears and based on the unit of service reimbursement rate shown on Exhibit D – Sierra AIDS Foundation FY 2010-11 Units of Service Summary, attached hereto and incorporated by reference herein.

CONTRACTOR shall submit monthly invoices no later than thirty (30) days following the end of a "service month" except in those instances where CONTRACTOR obtains written approval from COUNTY Health Services Department Director or Director's designee granting an extension of the time to complete billing for services or expenses. For billing purposes, a "service month" shall be defined as a calendar month during which CONTRACTOR provides services in accordance with Article II – Scope of Services.

Invoices shall be submitted to:

Health Services Department – Public Health Division
Finance Unit
941 Spring Street, Suite 3
Placerville, CA 95667

For services provided herein, COUNTY agrees to pay CONTRACTOR monthly in arrears and within forty-five (45) days following the COUNTY's receipt and approval of itemized invoice(s) identifying services rendered.

Article V. FUNDING-SPECIFIC PROVISIONS

Section 5.01 Subcontracting of Services

By signing this Agreement 108-095A-P-E2010, CONTRACTOR becomes a sub recipient of funds through the COUNTY Health Services Department and agrees to adhere to the terms and conditions of Exhibit B attached hereto and incorporated by reference as if fully set forth herein unless superseded by other exhibits attached hereto. In addition, CONTRACTOR agrees that in the event COUNTY agrees in writing to the subcontracting of any services under this Agreement, CONTRACTOR shall ensure that all subcontractor(s) adhere to terms and conditions of this Agreement.

Section 5.02 Nondiscrimination In Employment, Services, Benefits, and Facilities

(a) CONTRACTOR agrees and assures COUNTY that CONTRACTOR and any subcontractors shall comply with all applicable Federal, State, and local anti-discrimination laws, regulations, and ordinances and to not unlawfully discriminate, harass, or allow harassment against any employee, applicant for employment, employee or agent of COUNTY, or recipient of services contemplated to be provided or provided under this Agreement, because of race, ancestry, marital status, color, religious creed, political belief, national origin, ethnic group identification, sex, sexual orientation, age (over 40), medical condition (including HIV and AIDS), or physical or mental disability. CONTRACTOR shall ensure that the evaluation and treatment of its employees and applicants for employment, the treatment of COUNTY employees and agents, and recipients of services are free from such discrimination and harassment.

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

(c) CONTRACTOR agrees to compile data, maintain records and submit reports to permit effective enforcement of all applicable antidiscrimination laws and this provision.

Section 5.03 Admission Policies
CONTRACTOR's admission policies (if applicable) shall be in writing and available to the public and shall include a provision that patients are accepted for care without discrimination as described in this Agreement.

Section 5.04 Patient's Rights
CONTRACTOR shall give notice to all patients of their rights pursuant to and in compliance with: W&I Code Section 5325 et seq., and Title 9 CCR Section 860, et seq. In addition, in all facilities providing the services described herein, CONTRACTOR shall have prominently posted in the predominant language of the community a list of the patient's rights.

Section 5.05 Licensing and Staffing

(a) CONTRACTOR warrants that it and all its employees have all necessary licenses and /or permits required by the laws of the United States, the State of California, COUNTY, Sacramento County and all other appropriate governmental agencies, and agrees to maintain these licenses and permits in effect for the duration of this Agreement. Failure to maintain all the licenses and permits shall be deemed a breach of this Agreement and constitutes grounds for termination of this Agreement by COUNTY pursuant to Article XI.

(b) CONTRACTOR shall make available to COUNTY, on request of the Administrator for this Agreement, a list of the persons who will provide services under this Agreement. This shall state the name, title, professional degree, and work experience of such persons.

Section 5.06 Confidentiality

(a) CONTRACTOR is subject to and agrees to comply and require his or her employees to comply with, the provisions of Sections 5328, 10850 and 17006 of the W&I Code, Division 19-000 of the State of California Department of Social Services Manual of Policies and Procedures, Code of Federal Regulations Title 42, Chapter I, Part 2, and all other applicable laws and regulations to assure that:

(i) All applications and records concerning an individual made or kept by CONTRACTOR, COUNTY, or any public officer or agency in connection with the Welfare and Institutions Code relating to any form of public social services or health services provided under this Agreement shall be confidential and shall not be open to examination for any purpose not directly connected with the administration of such public social or health services.

(ii) No person will publish or disclose, or use or cause to be published, disclosed, or used, any confidential information pertaining to an applicant or recipient of services. Applicant and recipient records and information shall not be disclosed by CONTRACTOR to third parties without COUNTY's consent or the consent of the applicant/recipient.

(b) CONTRACTOR agrees to inform all of his/her employees, agents, subcontractors and partners of the above provision and that knowing and intentional violation of the provisions of said State law is a misdemeanor.

Section 5.07 Quality Assurance Program Review

(a) CONTRACTOR shall maintain adequate client records on each individual client, if applicable, which shall include face-to-face service plans, records of client interviews, case notes, and records of services provided by the various professional and paraprofessional personnel in sufficient detail to permit an evaluation of services. Such records must comply with all appropriate Federal, State and COUNTY record maintenance requirements as adopted by the Sacramento Eligible Metropolitan Area ("EMA") HIV Health Services ("Fiscal Agent").

(b) CONTRACTOR shall permit, at any reasonable time, personnel designated by COUNTY and/ or the Director of Sacramento County Department of Health and Human Services to come on CONTRACTOR's premises for the purpose of making periodic inspections to evaluate the effectiveness of the services rendered pursuant to this Agreement. At reasonable times during normal business hours, COUNTY or Sacramento County, and/or their appropriate audit agency or designee shall have the right to inspect or otherwise evaluate the cost, quality, appropriateness and timeliness of services performed and to audit and inspect any books and records of CONTRACTOR which pertain to services performed and determination of amount payable under this Agreement. CONTRACTOR shall furnish COUNTY or Sacramento County with such information as may be required to evaluate fiscal and program effectiveness of the services being rendered.

(c) CONTRACTOR shall actively participate and cooperate with any persons specified in Section 5.07(b) above in any evaluation or monitoring of services provided pursuant to this Agreement, and shall provide the above-mentioned persons adequate office space to conduct such evaluation or monitoring.

Section 5.08 Reports

(a) CONTRACTOR shall, on a monthly basis, provide to Contract Administrator, as defined in Article XXI herein, reports of the units of service performed.

(b) CONTRACTOR shall submit quarterly narrative reports directly to the EMA Fiscal Agent as outlined in the EMA Contractor's Manual with a copy to the Contract Administrator as defined in Article XXI herein.

(c) CONTRACTOR shall, without additional compensation therefore, make further fiscal, program evaluation, and progress reports as may be reasonably required by COUNTY or Sacramento County concerning CONTRACTOR's activities as they affect the contract duties and purposes herein. The Fiscal Agent shall explain procedures for reporting the required information.

(d) CONTRACTOR shall participate in the California Public Health Department active/passive case surveillance efforts promulgated by the State Office of AIDS.

Section 5.09 Claims for Payment

(a) It is understood that the validity of any billings, in terms of their compliance with Federal and State regulations, is subject to the review by the Comptroller of the United States, or any of their authorized representatives, any authorized representative of the State of California, any authorized representative of COUNTY and/or Sacramento County EMA (Fiscal Agent), and that COUNTY will be making payment on said billings in advance of said review and approval by the State and/or Federal government, or the Fiscal Agent, and in advance of the reimbursement by the Fiscal Agent to COUNTY for sums expended thereunder. In the event any claim is disapproved by the State and/or Federal government, or the Fiscal Agent, CONTRACTOR shall take all actions necessary to obtain such approval. In the event that COUNTY is not reimbursed by the Fiscal Agent for any amount it has paid to CONTRACTOR hereunder, on the basis of or as a result of the failure of CONTRACTOR to comply with any terms of this Agreement, or any of the State regulations governing the operation of this Agreement, CONTRACTOR shall reimburse COUNTY in the amount of such overpayment within thirty (30) days or, at sole discretion of COUNTY, COUNTY may withhold such amount from any payments due under this Agreement or any successor Agreement.

(b) It is understood that any records of revenues or expenditures under this Agreement may be subject to compliance with Federal or State regulations and may be audited by the appropriate Federal, State, or County agency. In the event of audit disallowance of any claimed cost that is subject to compliance with Federal or State regulations, COUNTY shall not be liable for any lost revenue resulting there from.

(c) CONTRACTOR shall maintain full and complete documentation of all expenses associated with performing these services covered under this Agreement. Expense documentation shall include: time sheets or payroll records for each employee; receipts for supplies; applicable subcontract expenditures; applicable overhead and indirect expenditures; and other such documentation required to substantiate overall costs of delivering the required services. All cost claims are subject to audit verification.

(d) If a post-Agreement audit, conducted in accordance with standard accounting procedures, finds that the actual aggregate costs for all services furnished pursuant to this Agreement are lower than the payments made by the COUNTY, or if any payments made by COUNTY are not reimbursable in accordance with the terms of the CARE Act Program reporting system, HRSA regulations regarding the use of Ryan White Title I funds, or the State Office of AIDS regulations regarding the use of Title II funds, the difference shall be repaid by CONTRACTOR forthwith by cash payment or at the sole discretion of COUNTY as a credit on future billings. If such post-Agreement audit finds that the actual cost of any services furnished hereunder are higher than the payments

made by COUNTY for that service, then the difference will not be paid to CONTRACTOR.

(e) In the event CONTRACTOR fails to comply with any provision of this Agreement, COUNTY shall withhold payment until such noncompliance has been corrected.

(f) In the event of termination of this Agreement prior to specified duration or in the event of non-renewal of contract services between CONTRACTOR and COUNTY, CONTRACTOR shall, within thirty (30) days of termination of this Agreement, declare to COUNTY any and all accounts receivables and assign to COUNTY billings to all clients and/or payers for services rendered clients for which claims have been or are being made to COUNTY for reimbursement.

Section 5.10 Use of Funds and Payment Limitation

(a) CONTRACTOR shall use the funds provided by COUNTY exclusively for the purposes of performing the services described in Exhibit A. It is understood and agreed that no funds provided by COUNTY pursuant to this Agreement shall be used for any political activity or political contribution.

(b) Exhibit A shall be the basis for and limitation of payments by COUNTY to CONTRACTOR for the services described in this Agreement. COUNTY shall pay to CONTRACTOR a sum not to exceed the lesser of:

(i) The not-to-exceed amount identified in Article IV.
(ii) The cost of services as determined pursuant to audit procedures as provided in this Agreement.

(c) Final settlement of COUNTY reimbursement to CONTRACTOR shall be based on CONTRACTOR's year-end Cost Report as submitted to the Sacramento EMA. In the event post-Agreement audit finds that the actual cost of any services furnished hereunder are higher than the payments made by COUNTY to CONTRACTOR for that service, then the difference will not be paid to CONTRACTOR, pursuant to Exhibit B - Agreement 7275-07/08-709, Exhibit D to Agreement, Article XIII paragraph E attached hereto and incorporated by reference herein.

(d) CONTRACTOR shall expend no more than five percent (5%) of the total Agreement amount for administrative and indirect costs pursuant to Article IV herein.

Section 5.11 Copyright Access

COUNTY shall have a royalty free, nonexclusive and irrevocable license to publish, translate, or use, now, or hereafter, all material developed under this Agreement including those covered by copyright.

Section 5.12 State and/or Federal Regulations
Services provided or performed under this Agreement shall be subject to and provided or performed in accordance with the following State or Federal regulations:

(a) Public Law 101-381, Ryan White Comprehensive AIDS Resources Emergency (CARE) Act;

(b) Public Law 104-146, Ryan White CARE Act Amendment of 1996; and

(c) 45 CFR Part 74 or 45 CFR Part 92, as applicable.

Section 5.13 Audit Requirements for Sub-Recipient of Federal Assistance Funds

(a) CONTRACTOR shall submit to the Contract Administrator an annual financial and compliance audit as described in the General Accounting Office's publication Governmental Audit Standards (GAS) prepared by an independent auditor. The audit shall reference Catalog of Federal Domestic Assistance (CFDA) 93.914 – HIV Emergency Relief Grant.

(b) The audit shall be conducted in accordance with generally accepted auditing standards and Government Auditing Standards, issued by the Comptroller General of the United States, and the Provisions Office of Management and Budget Circular "A-133".

(c) The Contract Administrator or his designee shall review the audit for completeness and findings, and then submit the audit to the Director of DHHS, for technical review. The Director of DHHS shall be allowed access to all financial and program records as DHHS deems necessary to determine that funding was spent in compliance with applicable guidelines of this Agreement.

(d) If the Agreement is terminated for any reason during the Agreement period, the independent audit shall cover the entire period of the Agreement for which services were provided.

(e) The audit shall be submitted to Contract Administrator or his/her designee within six (6) months of the end of the Agreement period.

(f) Following any audit report, in the event of non-compliance with applicable laws and regulations governing funds provided through this Agreement or serious deficiencies in CONTRACTOR's internal control structure, COUNTY may terminate this Agreement as provided for in Article XI or direct CONTRACTOR to immediately implement appropriate corrective action. A plan of corrective action shall be submitted to Administrator in writing within fifteen (15) days after receiving notice from COUNTY.

Article VI. CHANGES TO AGREEMENT
This Agreement may be amended by mutual consent of the parties hereto. Said amendments shall become effective only when in writing and fully executed by duly authorized officers of the parties hereto.

Article VII. CONTRACTOR TO COUNTY
It is understood that the services provided under this Agreement shall be prepared in and with cooperation from COUNTY and its staff. It is further agreed that in all matters pertaining to this Agreement, CONTRACTOR shall act as contractor only to COUNTY and shall not act as contractor to any other individual or entity affected by this Agreement nor provide information in any manner to any party outside of this Agreement that would conflict with CONTRACTOR's responsibilities to COUNTY during term hereof.

Article VIII. ASSIGNMENT AND DELEGATION
CONTRACTOR is engaged by COUNTY for its unique qualifications and skills as well as those of its personnel. CONTRACTOR shall not subcontract, delegate or assign services to be provided, in whole or in part, to any other person or entity without prior written consent of COUNTY.

Article IX. INDEPENDENT CONTRACTOR/LIABILITY
CONTRACTOR is, and shall be at all times, deemed independent and shall be wholly responsible for the manner in which it performs services required by terms of this Agreement. CONTRACTOR exclusively assumes responsibility for acts of its employees, associates, and subcontractors, if any are authorized herein, as they relate to services to be provided under this Agreement during the course and scope of their employment.

CONTRACTOR shall be responsible for performing the work under this Agreement in a safe, professional, skillful and workmanlike manner and shall be liable for its own negligence and negligent acts of its employees. COUNTY shall have no right of control over the manner in which work is to be done and shall, therefore, not be charged with responsibility of preventing risk to CONTRACTOR or its employees.

Article X. FISCAL CONSIDERATIONS
The parties to this Agreement recognize and acknowledge that COUNTY is a political subdivision of the State of California. As such, County of El Dorado is subject to the provisions of Article XVI, Section 18 of the California Constitution and other similar fiscal and procurement laws and regulations and may not expend funds for products, equipment or services not budgeted in a given fiscal year. It is further understood that in the normal course of COUNTY business, COUNTY will adopt a proposed budget prior to a given fiscal year, but that the final adoption of a budget does not occur until after the beginning of the fiscal year.

Notwithstanding any other provision of this Agreement to the contrary, COUNTY shall give notice of cancellation of this Agreement in the event of adoption of a proposed budget that does not provide for funds for the services, products or equipment subject herein. Such notice shall become effective upon the adoption of a final budget which does not provide funding for this Agreement. Upon the effective date of such notice, this Agreement shall be automatically terminated and COUNTY released from any further liability hereunder.

In addition to the above, should the Board of Supervisors during the course of a given year for financial reasons reduce, or order a reduction, in the budget for any COUNTY department for which services were contracted to be performed, pursuant to this paragraph in the sole discretion of the COUNTY, this Agreement may be deemed to be canceled in its entirety subject to payment for services performed prior to cancellation.

Article XI. DEFAULT, TERMINATION, AND CANCELLATION

Section 11.01 Default
Upon the occurrence of any default of the provisions of this Agreement, a party shall give written notice of said default to the party in default (notice). If the party in default does not cure the default within ten (10) days of the date of notice (time to cure), then such party shall be in default. The time to cure may be extended at the discretion of the party giving notice. Any extension of time to cure must be in writing, prepared by the party in default for signature by the party giving notice and must specify the reason(s) for the extension and the date on which the extension of time to cure expires.

Notice given under this section shall specify the alleged default and the applicable Agreement provision and shall demand that the party in default perform the provisions of this Agreement within the applicable period of time. No such notice shall be deemed a termination of this Agreement unless the party giving notice so elects in this notice, or the party giving notice so elects in a subsequent written notice after the time to cure has expired. In the event of termination for default, COUNTY reserves the right to take over and complete the work by contract or by any other means.

Section 11.02 Bankruptcy
This Agreement, at the option of the COUNTY, shall be terminable in the case of bankruptcy, voluntary or involuntary, or insolvency of CONTRACTOR.

Section 11.03 Ceasing Performance
COUNTY may terminate this Agreement in the event CONTRACTOR ceases to operate as a business, or otherwise becomes unable to substantially perform any term or condition of this Agreement.

Section 11.04 Termination or Cancellation without Cause
COUNTY may terminate this Agreement in whole or in part upon seven (7) calendar days written notice by COUNTY without cause. If such prior termination is effected, COUNTY will pay for

satisfactory services rendered prior to the effective dates as set forth in the Notice of Termination provided to CONTRACTOR, and for such other services, which COUNTY may agree to in writing as necessary for contract resolution. In no event, however, shall COUNTY be obligated to pay more than the total amount of the contract. Upon receipt of a Notice of Termination, CONTRACTOR shall promptly discontinue all services affected, as of the effective date of termination set forth in such Notice of Termination, unless the notice directs otherwise.

Article XII. NOTICE TO PARTIES

All notices to be given by the parties hereto shall be in writing and served by depositing same in the United States Post Office, postage prepaid and return receipt requested. Notices to COUNTY shall be addressed as follows:

COUNTY OF EL DORADO
HEALTH SERVICES DEPARTMENT
931 SPRING STREET
PLACERVILLE, CA 95667
ATTN: NEDA WEST, DIRECTOR

or to such other location as the COUNTY directs.

Notices to CONTRACTOR shall be addressed as follows:

SIERRA FOOTHILLS AIDS FOUNDATION
18183 LOCKSLEY, #205
AUBURN, CA 95602
ATTN: SUSAN FARRINGTON, EXECUTIVE DIRECTOR

or to such other location as the CONTRACTOR directs.

Article XIII. INDEMNITY

The CONTRACTOR shall defend, indemnify, and hold the COUNTY harmless against and from any and all claims, suits, losses, damages and liability for damages of every name, kind and description, including attorneys fees and costs incurred, brought for, or on account of, injuries to or death of any person, including but not limited to workers, COUNTY employees, and the public, or damage to property, or any economic or consequential losses, which are claimed to or in any way arise out of or are connected with the CONTRACTOR's services, operations, or performance hereunder, regardless of the existence or degree of fault or negligence on the part of the COUNTY, the CONTRACTOR, subcontractor(s) and employee(s) of any of these, except for the sole, or active negligence of the COUNTY, its officers and employees, or as expressly prescribed by statute. This duty of CONTRACTOR to indemnify and save COUNTY harmless includes the duties to defend set forth in California Civil Code Section 2778.

Article XIV. INSURANCE

Section 14.01 CONTRACTOR shall provide proof of a policy of insurance satisfactory to the County of El Dorado Risk Manager and documentation evidencing that CONTRACTOR maintains insurance that meets the following requirements:

(a) Full Workers' Compensation and Employers' Liability Insurance covering all employees of CONTRACTOR as required by law in the State of California; and
(b) Commercial General Liability Insurance of not less than $1,000,000 combined single limit per occurrence for bodily injury and property damage;
(c) Automobile Liability Insurance of not less than $1,000,000 is required in the event motor vehicles are used by the CONTRACTOR in the performance of the Agreement.
(d) In the event CONTRACTOR is a licensed professional, and is performing professional services under this Agreement, professional liability (for example, malpractice insurance) is required with a limit of liability of not less than $1,000,000 per occurrence.

Section 14.02 CONTRACTOR shall furnish a certificate of insurance satisfactory to the County of El Dorado Risk Manager as evidence that the insurance required above is being maintained.

Section 14.03 The insurance will be issued by an insurance company acceptable to Risk Management, or be provided through partial or total self-insurance likewise acceptable to Risk Management.

Section 14.04 CONTRACTOR agrees that the insurance required above shall be in effect at all times during the term of this Agreement. In the event said insurance coverage expires at any time or times during the term of this Agreement, CONTRACTOR agrees to provide at least thirty (30) days prior to said expiration date, a new certificate of insurance evidencing insurance coverage as provided for herein for not less than the remainder of the term of the Agreement, or for a period of not less than one (1) year. New certificates of insurance are subject to the approval of Risk Management and CONTRACTOR agrees that no work or services shall be performed prior to the giving of such approval. In the event the CONTRACTOR fails to keep in effect at all times insurance coverage as herein provided, COUNTY may, in addition to any other remedies it may have, terminate this Agreement upon the occurrence of such event.

Section 14.05 The certificate of insurance must include the following provisions stating that:

(a) The insurer will not cancel the insured's coverage without thirty (30) days prior written notice to COUNTY, and;

(b) The County of El Dorado, its officers, officials, employees, and volunteers are included as additional insured, but only insofar as the operations under this Agreement are concerned. This provision shall apply to the general liability policy.

Section 14.06 The CONTRACTOR's insurance coverage shall be primary insurance as respects the COUNTY, its officers, officials, employees and volunteers. Any insurance or self-insurance maintained by the COUNTY, its officers, officials, employees or volunteers shall be excess of the CONTRACTOR's insurance and shall not contribute with it.

Section 14.07 Any deductibles or self-insured retentions must be declared to and approved by the COUNTY, either: the insurer shall reduce or eliminate such deductibles or self-insured retentions as respects the COUNTY, its officers, officials, employees, and volunteers; or the CONTRACTOR shall procure a bond guaranteeing payment of losses and related investigations, claim administration and defense expenses.

Section 14.08 Any failure to comply with the reporting provisions of the policies shall not affect coverage provided to the COUNTY, its officers, officials, employees or volunteers.

Section 14.09 The insurance companies shall have no recourse against the County of El Dorado, its officers and employees or any of them for payment of any premiums or assessments under any policy issued by any insurance company.

Section 14.10 CONTRACTOR's obligations shall not be limited by the foregoing insurance requirements and shall survive expiration of this Agreement.

Section 14.11 In the event CONTRACTOR cannot provide an occurrence policy, CONTRACTOR shall provide insurance covering claims made as a result of performance of this Agreement for not less than three (3) years following completion of performance of this Agreement.

Section 14.12 Certificate of insurance shall meet such additional standards as may be determined by the contracting COUNTY Department either independently or in consultation with Risk Management, as essential for the protection of the COUNTY.

Article XV. INTEREST OF PUBLIC OFFICIAL

No official or employee of COUNTY who exercises any functions or responsibilities in review or approval of services to be provided by CONTRACTOR under this Agreement shall participate in or attempt to influence any decision relating to this Agreement which affects personal interest or interest of any corporation, partnership, or association in which he/she is directly or indirectly interested; nor shall any such official or employee of COUNTY have any interest, direct or indirect, in this Agreement or the proceeds thereof.

Article XVI. INTEREST OF CONTRACTOR

CONTRACTOR covenants that CONTRACTOR presently has no personal interest or financial interest, and shall not acquire same in any manner or degree in either: 1) any other contract connected with or directly affected by the services to be performed by this Agreement; or, 2) any other entities connected with or directly affected by the services to be performed by this

Agreement. CONTRACTOR further covenants that in the performance of this Agreement no person having any such interest shall be employed by CONTRACTOR.

Article XVII. CONFLICT OF INTEREST

The parties to this Agreement have read and are aware of the provisions of Government Code Section 1090 et seq. and Section 87100 relating to conflict of interest of public officers and employees. CONTRACTOR attests that it has no current business or financial relationship with any COUNTY employee(s) that would constitute a conflict of interest with provision of services under this contract and will not enter into any such business or financial relationship with any such employee(s) during the term of this Agreement. COUNTY represents that it is unaware of any financial or economic interest of any public officer or employee of CONTRACTOR relating to this Agreement. It is further understood and agreed that if such a financial interest does exist at the inception of this Agreement either party may immediately terminate this Agreement by giving written notice as detailed in the Article in the Agreement titled, "Default, Termination and Cancellation".

Article XVIII. CALIFORNIA RESIDENCY (FORM 590)

All independent Contractors providing services to the COUNTY must file a State of California Form 590, certifying their California residency or, in the case of a corporation, certifying that they have a permanent place of business in California. The CONTRACTOR will be required to submit a Form 590 prior to execution of an Agreement or COUNTY shall withhold seven (7) percent of each payment made to the CONTRACTOR during term of the Agreement. This requirement applies to any agreement/contract exceeding $1,500.00.

Article XIX. TAXPAYER IDENTIFICATION NUMBER (FORM W-9)

All independent Contractors or corporations providing services to the COUNTY must file a Department of the Treasury Internal Revenue Service Form W-9, certifying their Taxpayer Identification Number.

Article XX. COUNTY BUSINESS LICENSE

It is unlawful for any person to furnish supplies or services, or transact any kind of business in the unincorporated territory of County of El Dorado without possessing a County business license unless exempt under County Code Section 5.08.070.

Article XXI. ADMINISTRATOR

The COUNTY Officer or employee with responsibility for administering this Agreement is Michael Ungeheuer, RN, MN, PHN, Community Public Health Nursing Manager, or successor.

Article XXII. AUTHORIZED SIGNATURES

The parties to this Agreement represent that the undersigned individuals executing this Agreement on their respective behalf are fully authorized to do so by law or other appropriate instrument and to bind upon said parties to the obligations set forth herein.

Article XXIII. PARTIAL INVALIDITY

If any provision of this Agreement is held by a court of competent jurisdiction to be invalid, void or unenforceable, the remaining provisions will continue in full force and effect without being impaired or invalidated in any way.

Article XXIV. VENUE

Any dispute resolution action arising out of this Agreement, including, but not limited to, litigation, mediation, or arbitration, shall be brought in County of El Dorado, California, and shall be resolved in accordance with the laws of the State of California.

Article XXV. ENTIRE AGREEMENT

This document and the documents referred to herein or exhibits hereto are the entire Agreement between the parties and they incorporate or supersede all prior written or oral Agreements or understandings.

REQUESTING DEPARTMENT HEAD CONCURRENCE:

By: _____ Dated: 11/13/10

Neda West, Director
Health Services Department

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IN WITNESS WHEREOF, the parties hereto have executed this Agreement on the dates indicated below.

--COUNTY OF EL DORADO--

By: _____ Dated: _____

Norma Santiago, Chair
Board of Supervisors
COUNTY

Attest: Suzanne Allen de Sanchez
Clerk of the Board of Supervisors

_____ _____

Deputy Date

--CONTRACTOR--

By: _____ Dated: 11-16-10

Susan Farrington, Executive Director
Sierra Foothills AIDS Foundation
CONTRACTOR

EXHIBIT A
Sierra Foothills AIDS Foundation – CARE Act Program
SCOPE OF SERVICES

Article I. Service Locations

Sierra Foothills AIDS Foundation
3053 Harrison Avenue, Suite 203
South Lake Tahoe, CA 96151

Sierra Foothills AIDS Foundation
550 Pleasant Valley Road, Suite 2-E
Diamond Springs, CA 95619

Article II. County Residency

Funding provided under this Agreement for Services is to be used for Sacramento, El Dorado and Placer County residents only. A person is a Sacramento, El Dorado or Placer County resident if he/she is currently staying in one of these counties with the intent to remain and live in one of the aforementioned counties. Any person who comes to Sacramento, El Dorado or Placer County for the express purpose of qualifying to receive services from a COUNTY-funded program and intends to leave the COUNTY after receipt of services, is not considered a resident. Proof of residency can be established by one or more of the following:

- Any bill or correspondence current to within the previous two weeks showing the individual's name and a Sacramento, El Dorado or Placer County address;
- Written statement by homeless shelter staff verifying that the individual has been in shelter residence in Sacramento, El Dorado or Placer County continuously fo the previous two weeks;
- Current State-issued identification card reflecting a Sacramento, El Dorado or Placer County address; and/or
- Other reliable evidence that establishes Sacramento, El Dorado or Placer County residency.

Article III. CONTRACTOR shall:

Section 3.01 Ensure that all work performed under this Agreement is in full compliance with all applicable provisions of Part A of the Ryan White CARE Act and/or Health Resources and Services Administration (HRSA) approved policies and procedures.

Section 3.02 Comply with all HRSA, State Office of AIDS (SOA), and the Sacramento Eligible Metropolitan Area (EMA) reporting requirements in a timely manner as specified by the Fiscal Agent of the EMA.

Section 3.03 Integrate service directives and/or standards developed and adopted by the HIV Health Services Planning Council into existing progam models. If applicable, these directives and/or standards will be furnished to the CONTRACTOR along with this Agreement. The CONTRACTOR may request an exemption from certain provisions of the Council Service Directives and/or standards through written request to the the Fiscal Agent of the Sacramento EMA. The Fiscal Agent retains discretionary authority to approve or deny requests for any exemption. All exemption requests, with narrative justification, must be submitted in writing in advance of anticipated need.

Section 3.04 Track and report needs of clients, including documentation of any needs that are not provided for by funding under Part A of the CARE Act.

Section 3.05 Participate in the development of a continuum of care, including development of a comprehensive plan for the EMA. This process will also require establishment and maintenance of cooperative working relationships with other service providers within the region continuum of care.

Section 3.06 Process consumer complaints and/or grievances in a manner consistent with established agency grievance procedures. Agency grievance policies and procedures must be prominently posted at each agency. Consumers are to be furnished with a copy of said procedures on request.

Section 3.07 CONTRACTOR SHALL PROVIDE THE FOLLOWING SERVICES

(A) Ambulatory/Outpatient Medical Care, pursuant to Exhibit A-1, Amendment 4 to Agreement 7275-07/12-709-A4, attached hereto as "Exhibit A – Attachment 1," and incorporated by reference as if fully set forth herein.

(i) CONTRACTOR shall use best efforts to achieve the outcomes described below, and to provide the levels of service delivery as follows:
1) Number of Unduplicated Clients:
a) An estimated one hundred thirty-four (134) unduplicated clients will receive Ambulatory/Outpatient Medical Services during fiscal year (FY) 2010-11.
2) Number of Units of Services:
a) A minimum of one (1) unit of service per client and an overall maximum of four thousand, six hundred eighty-one and 62/100 (4,681.62) units of service will be provided during FY 2010-11.
b) A minimum of one (1) unit of service per client and an overall maximum of four hundred seventy-eight and 18/100 (478.18) laboratory units of service will be provided during FY 2010-11.
c) A minimum of one (1) unit of service per client and an overall maximum of one hundred nine and 9/10 (109.9) specialty care units of service will be provided during FY 2010-11.

(ii) CONTRACTOR shall use best efforts to achieve the outcomes, as evidenced by:
1) Documentation of on-going medical care will be charted in case files for one hundred percent (100%) of clients.
2) The number of hospital admissions as a ratio of the annual unduplicated caseload will be tracked and trended.
3) The number of emergency room visits as a ratio of the annual unduplicated caseload will be tracked and trended.
4) CD4 Counts and Viral Load counts as a ratio of the annual unduplicated caseload will be tracked and trended.
5) Death Rates per year as a percentage of annual unduplicated clients will be tracked and trended.
6) Seventy percent (70%) of clients will receive a minimum of one primary care visit per year (twelve [12] month period).
7) CONTRACTOR shall document and track all service provision to clients through the SEMAS web-based database to identify clients who may withdraw from care.
8) CONTRACTOR will provide screening and treatment to ninety-five percent (95%) of clients reporting opportunistic infections who remain in care.
9) Sixty percent (60%) of clients on HAART therapy will show improved or stable CD4 and viral load counts.
10) One-hundred percent (100%) of primary care services offered will meet Public Health Standard guidelines.

(B) Medical Case Management, pursuant to Exhibit A-2, Amendment 4 to Agreement 7275-07/12-709-A4, attached hereto as "Exhibit A – Attachment 2," and incorporated by reference as if fully set forth herein.

(i) CONTRACTOR shall use best efforts to achieve the outcomes described below, and to provide the level of service delivery as follows:
1) Number of Unduplicated Clients:

a) A minimum of one (1) and a maximum of one hundred nineteen (119) clients will receive medical case management services during FY 2010-11.

2) Number of Units of Services (one (1) unit of service equals fifteen (15) minutes of field based face-to-face encounter or fifteen (15) minutes of field based other encounter):

a) A minimum of eight (8) units of service per client and an overall maximum of seven thousand, seven hundred eighty-five and 1/100 (7,785.01) units of service will be provided not to exceed the total contract award during FY 2010-11.

(ii) CONTRACTOR shall use best efforts to achieve the outcomes, as evidenced by:

1) One hundred percent (100%) of participants will have had an assessment of medical and psychosocial needs, which determined appropriate resource referrals.
2) One hundred percent (100%) of program participants will have a CARE PLAN prioritizing needs and identifying goals to meet those needs.
3) Seventy percent (70%) of unduplicated clients will maintain/achieve their individual CARE PLAN objectives as measured over twelve (12) months.
4) Documentation of assistance provided will be charted in case files for one hundred percent (100%) of clients.
5) One hundred percent (100%) of participants will be reassessed at least once during the project year.
6) Documentation of on-going medical care will be charted in case files for one hundred percent (100%) of clients.
7) CONTRACTOR will document and track all service provision to clients through the SEMAS web-based database in order to identify clients who may withdraw from care.
8) One hundred percent (100%) of clients who do not have an identified primary care provider at intake will receive a referral to an appropriate physician or clinic.
9) Seventy percent (70%) of clients receiving medical case management will maintain routine medical care (minimum three (3) primary care visits per year that includes CD4 count, viral load test or an ART therapy).

(C) Mental Health Treatment Services For Client, Family Members And Caregivers, pursuant to Exhibit A-3, Amendment 4 to Agreement 7275-07/12-709-A4, attached hereto as "Exhibit A – Attachment 3," and incorporated by reference as if fully set forth herein.

(i) CONTRACTOR shall use best efforts to achieve the outcomes described below, and to provide the level of service delivery as follows:

1) Number of Unduplicated Clients:

a) A minimum of two (2) adults will receive individual psychological counseling services during FY 2010-11.

2) Number of Units of Services (one (1) unit of service = one (1) vendor paid dollar for individual psychological counseling session):

a) A maximum of one thousand, seven hundred sixty-four and 55/100 (1,764.55) units of service will be provided at the maximum billing rate during FY 2010-11.

(ii) CONTRACTOR shall use best efforts to achieve the outcomes, as evidenced by:

1) One hundred percent (100%) of participants will have completed a pre-survey prior to or on their first mental health appointment at the agency or if the person is a continuing client they will have completed a pre-survey on their first appointment of each CARE Program fiscal year commencing March 1.

2) One hundred percent (100%) of participants will have completed a post-survey at the time they complete treatment at the agency or at the end of each CARE Program fiscal year on February 28, whichever event comes first.
3) One hundred percent (100%) of long-term ongoing clients will have completed a post-survey one (1) year after they began receiving treatment at the agency and again each year following to track the progress of treatment.
4) One hundred percent (100%) of client survey responses will be reported to the Sacramento EMA CARE Act Program.
5) One hundred percent (100%) of clients who do not have an identified primary care provider at the time of Intake will receive a referral and access to appropriate physician or clinic during the program year.
6) Sixty percent (60%) of HIV-positive clients who receive mental health services will report increased functionality within ninety (90) days of start of treatment.

(D) Support Service – Medical Transportation, pursuant to Exhibit A-4, Amendment 4 to Agreement 7275-07/12-709-A4, attached hereto as "Exhibit A – Attachment 4," and incorporated by reference as if fully set forth herein.

(i) CONTRACTOR shall provide a minimum level of service delivery as follows:
1) SS-Medical Transportation: Conveyance services provided to a client in order to access medical care or HIV-related psychosocial services and medical transportation to basic local, State and Federal entitlement program facility sites within the TGA only. Conveyance may be provided through joint-agency arrangement for volunteer-based transportation services, routinely or on an emergency basis via bus passes, or as a last resort, and clearly documented as an immediate need, taxicab services through an appropriate vendor.
2) Unduplicated Clients:
a) A minimum of forty-two (42) clients will receive transportation assistance during Fiscal Year 2010-11.
3) Units of Service (one (1) unit of service = one (1) vendor paid transportation dollar):
a) A maximum of three thousand, five hundred forty and 91/100 (3,540.91) units of service will be provided at the maximum billing rate during Fiscal Year 2010-11.

(ii) Intended Outcomes:
1) CONTRACTOR shall strive to achieve the minimum and maximum service deliveries as described in Section 3.07(D).
2) CONTRACTOR shall ensure documentation of intake process be charted in case files for one hundred percent (100%) of clients.
3) CONTRACTOR shall ensure that one hundred percent (100%) of program participants have a CARE PLAN developed by a Sacramento EMA Ryan White CARE Program funded case management agency. Exceptions: clients receiving Volunteer-based Transportation Services, Buddy/Companion Services, and/or Service Outreach/Case Finding, which do not require case management participation.
4) CONTRACTOR shall offer one hundred percent (100%) of participants an array of transportation service options to overcome barriers to accessing primary medical care.
5) CONTRACTOR shall document and track all service provision to clients through the SEMAS web-based database to indentify clients who may withdraw from care.
6) CONTRACTOR shall ensure documentation of on-going medical care will be charted in case files for one hundred percent (100%) of clients.

7) CONTRACTOR shall document all other resources available to client and other private and community resources attempted and/or accessed prior to using Ryan White CARE Act funds (i.e. payer of last resort).
8) Seventy percent (70%) of Medical Transportation clients will maintain routine medical care (minimum of one (1) primary care visit per year that includes a CD4 count, viral load or on ART).
9) Seventy-five percent (75%) of clients showing evidence of need for medical transportation services will receive transportation for HIV/AIDS related care appointments.

(E) Emergency Financial Assistance, pursuant to Exhibit A-5, Amendment 4 to Agreement 7275-07/12-709-A4, attached hereto as "Exhibit A – Attachment 5," and incorporated by reference as if fully set forth herein.

(i) CONTRACTOR shall provide a minimum level of service delivery as follows:
1) Other Critical Needs: Services developed to meet the needs of clients not listed in other support service categories, such as short-term direct emergency financial assistance for health insurance premiums and other critical needs. Payment on behalf of client shall be made to the provider of said assistance or need directly. CARE Program funded clients shall not receive any direct financial assistance payments.
2) Unduplicated clients:
a) A minimum of forty-eight (48) clients will receive emergency financial assistance for other critical needs during Fiscal Year 2010-11.
3) Units of service (one (1) unit of service = one (1) vendor paid food dollar):
a) A maximum of nine thousand, seven hundred fifty-two and 73/100 (9,752.73) units of service will be provided at the maximum billing rate during Fiscal Year 2010-11.

(ii) Intended Outcomes
1) CONTRACTOR shall strive to achieve the minimum and maximum service deliveries as described above.
2) CONTRACTOR shall ensure documentation of intake process be charted in case files for one hundred percent (100%) of clients.
3) CONTRACTOR shall ensure that one hundred percent (100%) of program participants have a CARE PLAN developed by a Sacramento EMA Ryan White CARE Program funded case management agency.
4) CONTRACTOR shall offer one hundred percent (100%) of participants' emergency financial assistance to overcome barriers to accessing primary medical care.
5) CONTRACTOR shall document in individualized case file for one hundred percent (100%) of clients: Proof of need of payment (e.g. copy of utility/telephone cut-off notice/bill, vendor invoice, etc.); appropriate signed release of information forms; all contact with client; resource referrals; and case notes.
6) CONTRACTOR shall document all other resources available to client and other private and community resources attempted and/or accessed prior to using Ryan White CARE Act funds (i.e. payor of last resort).
7) CONTRACTOR shall document and track all service provision to clients through the SEMAS web-based database to identify clients who may withdraw from care.
8) Documentation of on-going medical care will be charted in case files for one hundred percent (100%) of clients.
9) Seventy percent (70%) of clients accessing Emergency Financial Assistance will continue to access routine medical care (minimum one primary care visit per year that includes CD4 count, viral load test or on ART).

10) CONTRACTOR shall adhere to service standards and directives as determined by the HIV Health Services Planning Council.

(F) Dental Care, pursuant to Exhibit A-6, Amendment 4 to Agreement 7275-07/12-709-A4, attached hereto as "Exhibit A – Attachment 6," and incorporated by reference as if fully set forth herein. CONTRACTOR shall adhere to the terms and conditions set forth in the Ryan White HIV Dental Program Operations Manual (Attachment A Amendment 4), attached hereto as Exhibit A – Attachment 7, and incorporated by reference as if fully set forth herein.

(i) CONTRACTOR shall use best efforts to achieve the outcomes described below:

1) Number of unduplicated clients:
   a) A maximum of two (2) clients will receive Oral Health Care during FY 2010-11.
2) Number of Units of Services (one (1) unit of serviced = one (1) vendor paid dollar for dental visit):
   a) A minimum of one (1) unit of service per client and an overall maximum of four thousand, three hundred twenty-three and 64/100 (4,323.64) units of service will be provided at the maximum billing rate during FY 2010-11.
3) Seventy percent (70%) of dental clients will maintain routine medical care (minimum of three (3) primary care visits per year that includes a CD4 count, viral load or on ART therapy).
4) One hundred percent (100%) of dental clients who do not have an identified primary care provider at intake will receive a referral to an appropriate physician or clinic.

ATTACHMENT A AMENDMENT 4

RYAN WHITE HIV DENTAL PROGRAM
OPERATIONS MANUAL

I. CRITERIA FOR DENTAL SERVICES UNDER THE PART A and SINGLE ALLOCATION METHOD (SAM) RYAN WHITE PROGRAM

This document is a compilation of criteria which apply to dental services. It is designated to provide assistance to dentists treating beneficiaries, in determining service authorization and payment. These criteria are designated to ensure that program funds are spent on services that are medically necessary and are in substantial compliance with the Ryan White HIV Dental Program Policy, and generally accepted standards of dental practice. However, these criteria are but guidelines with which to apply professional judgement in assuring that dental services are appropriate, necessary and of high quality. Professional judgement shall be applied in the determination of benefits and/or payment on the basis of these reliable and valid criteria, evaluation, and interpretation of diagnostic material. Providers and County consultants have established these criteria to standardize the exercise of professional judgement. However, it should be pointed out that this listing does not establish a requirement that consultants must authorize services which meet the criteria listed.

II. REASONABLE AND NECESSARY CONCEPT

A. Outpatient dental services which are reasonable and necessary for the diagnosis and treatment of dental disease, injury, or defect are covered.

B. The underlying principle of whether a service is reasonable and necessary is whether or not the requested service or item is in accord with generally accepted standards of dental practice and is indispensable to the oral health of the beneficiary. Treatment shall be granted or reimbursement made only for covered services appropriate to the present adverse condition which has been approved according to program requirements.

III. EMERGENCY DENTAL SERVICES

A. Within the scope of dental care benefits under the program, emergency dental services may comprise those diverse professional services required in the event of unforeseen medical conditions such as hemorrhage, infection, or trauma. Emergency service shall conform to acceptable standards within our community. Examples of emergency conditions may include, but are not limited to the following:

1. High risk-to life or minimally disabling conditions, *e.g.*, painful oral-dental infections, pulpal exposures, and fractured teeth.

B. Possible emergency dental treatment may include, but is not limited to: antibiotics administrations; prescriptions of analgesics or antibiotics; temporary or permanent filling; pulpal treatment, where sedative holding measures are not effective; biopsy; denture adjustment; treatment of evulsed teeth; control of post-operative bleeding; treatment for acute periodontitis.

IV. DENTIST PARTICIPATION INFORMATION

The fee payable to providers is at the negotiated rate, as stated in the provider's contracted fee schedule, for covered services.

V. PRIOR AUTHORIZATION

A. Prior authorization by a County representative may be required for dental services including but not limited to endodontic and periodontic treatment, cast partials, castings, dentures, and referrals to outside dental specialty providers (see covered services for specifics).

B. The cost of hospitalization is **not** covered. The dental procedures performed during hospitalization will be covered at the same rate specified in the provider's contracted fee schedule. No other hospital related costs are covered.

VI. UNLISTED PROCEDURES (9999)

A. Complete description of the proposed treatment and the need for service must be documented.

B. The fee requested must be listed and is subject to review by County representatives.

C. Non-emergency unlisted procedures require prior authorization.

VII. COVERED PROCEDURES

A. DIAGNOSTIC

Procedure 0110	Examination, initial episode of treatment only. Radiographs are covered when taken in compliance with state and federal regulations for radiation hygiene, and when they fully depict subject teeth and associated structures by standard illumination, and are appropriate to the symptoms and conditions of the patient.
Procedure 0120	Periodic oral examination limited to any two examinations (0110, 0120, 0130) per contract year.
Procedure 0210	Intraoral, complete series when medically necessary and in accepted standards of dental practice. Limited to once in a three (3) year period.
Procedure 0230	Intraoral periapical, each additional film (maximum ten films).
Procedure 0240	Intraoral, occlusal film.
Procedure 0272	Bitewings, two films. Limited to once per contract year.
Procedure 0274	Bitewings, four films. Limited to once per contract year.
Procedure 0330	Panographic-type film, single film. Limited to once every three (3) years.
Procedure 0470	Diagnostic casts.

B. PREVENTIVE – Covered only when in conjunction with restorative procedures and limited to two (2) times per contract year.

Procedure 1110	Prophylaxis – adult, limited to two (2) times per contract year.
Procedure 1120	Prophylaxis – child, limited to two (2) times per contract year.
Procedure 1201	Topical application of fluoride (including prophylaxis) – child.
Procedure 1203	Topical application of fluoride (prophylaxis not included) – child.
Procedure 1204	Topical application of fluoride (including prophylaxis) – adult.
Procedure 1205	Topical application of fluoride (prophylaxis not included) – adult.
Procedure 1351	Sealant – per tooth, children only.

C. RESTORATIVE DENTISTRY

1. The program provides temporary restoration, amalgam, composite, or plastic restorations for treatment of caries. If the tooth can be restored with such material, any crown or jacket is not covered.

2. Laboratory processed crowns are benefits for permanent anterior teeth and permanent posterior teeth once in a five (5) year period.

3. When a crown is placed on a posterior molar tooth, porcelain, resin and similar materials are optional. An allowance will be made based on the fee for a full metal crown.

4. Authorization may be granted for the lowest cost item or service that meets the patient's medical needs. When acting upon request for approval for laboratory processed crowns, these regulations as well as the overall condition of the mouth, patient's receptivity toward treatment and willingness to comply with maintaining good oral hygiene, oral health status, arch integrity, and prognosis of remaining teeth shall be considered.

5. Laboratory processed crowns may be granted where longevity is essential and a lesser service will not suffice, when extensive coronal destruction is radiographically demonstrated and treatment is beyond intercoronal restoration.

6. Cast or performed posts are covered for devitalized teeth only.

7. Laboratory process crowns on endodontically treated teeth are covered only after satisfactory completion of the root canal therapy.

Procedure 2110	Amalgam restoration, primary tooth, one surface.
Procedure 2120	Amalgam restoration primary tooth, two surfaces.
Procedure 2130	Amalgam restoration, primary tooth, three surfaces.
Procedure 2131	Amalgam restoration, primary tooth, four or more surfaces.
Procedure 2140	Amalgam restoration, permanent tooth, one surface.
Procedure 2150	Amalgam restoration, permanent tooth, two surfaces.
Procedure 2160	Amalgam restoration, permanent tooth, three surfaces.
Procedure 2161	Amalgam restoration, permanent tooth, four or more surfaces.
Procedure 2330	Composite restoration, one surface – anterior tooth.
Procedure 2331	Composite restoration, two surfaces – anterior tooth.
Procedure 2332	Composite restoration, three surfaces – anterior tooth.
Procedure 2335	Composite restoration, four or more surfaces or involving incisal angle – anterior.
Procedure 2750	Crown, porcelain fused to metal (anterior teeth only).
Procedure 2790	Crown, full case high noble metal.
Procedure 2910	Re-cement inlay, facing, pontic.
Procedure 2920	Re-cement crown.
Procedure 2930	Crown stainless steel, primary.
Procedure 2931	Crown stainless steel, permanent.
Procedure 2950	Core buildup, including any pins.
Procedure 2951	Pin retention (per pin), maximum three pins per tooth.

Procedure 2952 Cast post and core, in addition to crown.

Procedure 2954 Prefabricated post and core, in addition to crown.

Procedure 2970 Temporary crown or stainless steel band.

D. ENDODONTICS – GENERAL POLICIES

1. Includes those procedures when complete root canal filling on permanent teeth:

   a. Root canal therapy is a covered benefit, if medically necessary – tooth is non-vital. The prognosis of the affected tooth and other remaining teeth will be evaluated in considering root canal therapy.

   b. Authorization and payment for root canal treatment includes, but is not limited to, any of the following procedures:

      Any incision and drainage necessary on relation to the root canal therapy.

      Vitality test.

      Radiographs required during treatment.

      Culture.

      Medicated treatment.

      Final filling of canals.

      Final treatment radiographs.

   c. Necessary retreatment and postoperative care within a 90-day period is included in the reimbursement fee for the root canal therapy.

   d. Root canal therapy must be completed prior to payment. Date of service on the claim for payment must reflect the final completion date.

2. Emergency root canal treatment may be done when any of the following conditions exist and **documentation substantiates the need**:

   a. Failure of a palliative treatment to relieve the acute distress of the patient.

   b. When a tooth has been accidentally evulsed.

   c. When there has been a fracture of the crown of a tooth exposing the pulpal tissue.

3. The prognosis of the affected tooth, other remaining teeth, and the type of restorations allowable will be evaluated in considering requested root canal therapy.

4. Extraction may be suggested for a tooth with a fractured root, external or internal resorption, or one that is easily replaced by addition to an existing removable dental appliance.

Procedure 3110 Pulp cap – direct (excluding final restoration).

Procedure 3120 Pulp cap – indirect (excluding final restoration).

Procedure 3220 Therapeutic pulpotomy (excluding final restoration).

Procedure 3310	Anterior root canal therapy (excluding final restoration).
Procedure 3320	Bicuspid root canal therapy (excluding final restoration).
Procedure 3330	Molar root canal therapy (excluding final restoration).
Procedure 3410	Apicoectomy (separate surgical procedure) per tooth: This procedure when there is severe apical curvature, blockage of the canal by calcific deposits, dentinal shavings or pulp chamber debris, and when a canal wall has been perforated or "shelved" during canal enlargement.

E. PERIODONTICS

1. PERIODONTICS – GENERAL POLICIES

Accepted dental practice indicates that periodontal treatment should use therapeutic measures on an ordered schedule limited to the direct, least invasive measures necessary to achieve the result.

Procedure 4210	Gingivectomy or gingivoplasty – per quadrant.
Procedure 4211	Gingivectomy or gingivoplasty, treatment per tooth (fewer than six teeth): May be authorized when an isolated pocket has not responded to conservative treatment.
Procedure 4220	Gingival curettage, surgical, per quadrant, by report.
Procedure 4240	Gingival flap procedure, including root planning – per quadrant.
Procedure 4341	Subgingival curettage and root planning, per treatment: Root planing includes the removal of calculus deposits on the tooth and root, the smoothing of the root and surface; subgingival curettage – the removal of granulation tissue and pocket lining epithelium. Treatment is limited to those areas requiring immediate attention.
Procedure 4910	Periodontal maintenance procedures (following active therapy).

F. PROSTHETICS - REMOVABLE

1. Full dentures are covered when medically necessary using standard procedures which exclude precision attachments, implants or other specialized techniques. These services are covered only once in a five year period

   a. Prevent a significant disability.

   b. Replace a covered removable dental prosthesis which has been lost or destroyed due to circumstances beyond the beneficiary's control.

2. Request for the extraction of all remaining teeth in preparation for complete immediate dentures and the immediate full dentures following full mouth extractions (both anterior and posterior) is a covered benefit.

3. Construction of new dentures shall not be authorized if conditions including but not limited to the following exist:

   a. It would be impossible or highly improbable for a beneficiary to adjust to a new prosthetic appliance. This is particularly applicable in those cases where the patient has been without dentures for an extended period of time or where the beneficiary may exhibit a poor adaptability due to psychological and/or motor deficiencies.

   b. The dental history shows that any or all dentures made in recent years have been unsatisfactory for reasons that are not remediable (psychological).

   c. Repair, relining, or reconstruction of the recipient's present denture will make it serviceable.

d. The denture, in the patient's opinion only, is loose or ill-fitting but is recently enough constructed to indicate deficiencies limited to those inherent in all dentures.

e. Where the request for the denture(s) is primarily cosmetic, the authorization shall be denied.

f. The patient has been without dentures for at least five (5) years and is currently functioning without dentures.

4. Immediate dentures may be authorized when conditions including but not limited to the following exist:

a. Extensive or rampant caries are exhibited.

b. Severe periodontal involvement is indicated.

i. When the clinical exam shows excessive mobility and severe gingivitis.

ii. When tooth mobility is not grossly evident and when the gingival tissues are not severely involved, consideration should be given to a more conservative treatment and denture request denied.

c. Numerous teeth are missing and masticating ability has been diminished.

i. Where there is not capability of any posterior occlusion with existing dentition.

ii. When a functional, although minimal, occlusion exists, the urgent need for prosthesis should be carefully evaluated.

5. Requests for replacement dentures shall include adequate supportive documentation and shall be preauthorized. Replacement dentures may be authorized more often than once in a five (5) year period when:

a. Catastrophic loss of denture.

b. Surgical or traumatic loss of oral-facial anatomic structures.

c. Replacement of existing dentures.

i. When there has been a complete deterioration of the denture base or teeth.

ii. When there has been a complete loss of retentive ability, vertical dimension, or balanced occlusion of existing dentures.

6. Requests for dentures for the long-standing edentulous patient will be denied.

7. A removable Partial denture is covered when necessary for the replacement of anterior teeth only.

8. A covered removable partial denture may be authorized only once in a five (5) year period except to:

a. Prevent a significant disability.

b. Replace a covered removable dental prosthesis which has been lost or destroyed due to circumstances beyond the beneficiary's control.

Procedure 5110 Complete denture - maxillary.

Procedure 5120 Complete denture – mandibular.

Procedure 5130 Immediate denture – maxillary.

Procedure 5140 Immediate denture – mandibular.

Procedure 5211	Maxillary partial denture – resin base (including any conventional clasps, rests and teeth).
Procedure 5212	Mandibular partial denture – resin base (including any conventional clasps, rests and teeth).
Procedure 5213	Maxillary partial denture – predominantly base metal (including any conventional clasps, rests and teeth).
Procedure 5214	Mandibular partial denture – predominantly base metal (including any conventional clasps, rests and teeth).
Procedure 5410	Denture adjustment – maxillary denture.
Procedure 5411	Denture adjustment – mandibular denture.
Procedure 5421	Denture adjustment – maxillary partial.
Procedure 5422	Denture adjustment – mandibular partial.
Procedure 5510	Repair broken denture base only (complete or partial).
Procedure 5520	Replace broken denture teeth only.
Procedure 5610	Repair resin denture base.
Procedure 5620	Repair cast framework.
Procedure 5630	Repair or replace clasp.
Procedure 5640	Replace broken teeth – per tooth
Procedure 5650	Add tooth to partial denture to replace newly extracted natural tooth.
Procedure 5660	Add clasp to existing partial denture.
Procedure 5710	Rebase complete maxillary denture.
Procedure 5711	Rebase complete mandibular denture.
Procedure 5720	Rebase maxillary partial denture.
Procedure 5721	Rebase mandibular partial denture.
Procedure 5730	Reline complete maxillary denture – chairside.
Procedure 5731	Reline complete mandibular denture – chairside.
Procedure 5740	Reline partial maxillary denture – chairside.
Procedure 5741	Reline partial mandibular denture – chairside.
Procedure 5750	Reline complete maxillary denture – lab.
Procedure 5751	Reline complete mandibular denture – lab.
Procedure 5760	Reline partial maxillary denture – lab.
Procedure 5761	Reline partial mandibular denture – lab.
Procedure 5810	Interim complete denture (maxillary).

Procedure 5811	Interim complete denture (mandibular).
Procedure 5820	Interim partial denture (maxillary).
Procedure 5821	Interim partial denture (mandibular).
Procedure 5850	Tissue conditioning – maxillary.
Procedure 5851	Tissue conditioning – mandibular.

G. PROSTHETICS - FIXED

Procedure 6210	Pontic-cast with high noble metal.
Procedure 6240	Pontic-porcelain with high noble metal.
Procedure 6250	Pontic-resin with high noble metal.
Procedure 6750	Bridge crown-porcelain with high noble metal.
Procedure 6790	Bridge crown-full case with high noble metal.
Procedure 6930	Re-cement bridge.
Procedure 6940	Stress breaker.
Procedure 6970	Cast post and core in addition to bridge crown (endodontically treated tooth).
Procedure 6971	Cast post as part of bridge crown.
Procedure 6972	Prefabricated post and core in addition to bridge crown (endodontically treated tooth).
Procedure 6980	Repair fixed bridge.
Procedure 6999	Unspecified fixed prosthodontic procedure, by report.

H. ORAL SURGERY

1. EXTRACTIONS – GENERAL POLICIES

a. Diagnostic x-rays fully depicting subject tooth (teeth) are usually required for all intraoral surgical procedures. (See specific procedure code for details)

b. The extraction of asymptomatic teeth is not a benefit.

The following instances may be justified as being symptomatic:

i. Teeth which are involved with a cyst, tumor, or neoplasm.

ii. The extraction of all remaining teeth in preparation for a full prosthesis.

iii. A malaligned tooth that causes intermittent gingival inflammation.

iv. Perceptible radiologic pathology that fails to elicit symptoms.

c. By repot procedures may be used when the provider has encountered unforeseen complications which are not usually considered normal to the particular procedure listed.

Procedure 7110 Removal of erupted tooth, uncomplicated, first tooth

Procedure 7120	Removal of erupted tooth (teeth), uncomplicated, each additional tooth.
Procedure 7130	Removal of root or root tip.
Procedure 7210	Removal of erupted tooth, surgical.
Procedure 7220	Removal of impacted tooth – soft tissue: Removal of any permanent tooth by the open method which may or may not include removal of bone in those cases where the major portion of all of the crown of the tooth was covered by mucogingival tissue and not alveolar bone.
Procedure 7230	Removal of impacted tooth – partially bony.
Procedure 7240	Removal of impacted tooth – totally bony: Removal of any tooth by the open method where it is necessary to expose any portion of the crown of the tooth by removal of alveolar bone.
Procedure 7250	Surgical removal of residual tooth roots (cutting procedure).
Procedure 7285	Biopsy and pathology reports of oral tissue – hard: Refer to oral surgeon.
Procedure 7286	Biopsy and pathology reports of oral tissue – soft: Refer to oral surgeon.
Procedure 7310	Alveolectomy (Alveoloplasty): Is a collective term for the operation by which the shape and condition of the alveolar process is improved for preservation of the residual bone.
Procedure 7430	Excision of benign tumor – lesion diameter up to 1.25 cm.
Procedure 7431	Excision of benign tumor – lesion diameter greater than 1.25 cm.
Procedure 7440	Excision of malignant tumor – lesion diameter up to 1.25 cm.
Procedure 7441	Excision of malignant tumor – lesion diameter greater than 1.25 cm.
Procedure 7465	Destruction of lesion(s) by physical or chemical methods, by report.
Procedure 7510	Incision and drainage of abscess, intraoral soft tissue.
Procedure 7520	Incision and drainage of abscess, extraoral soft tissue.
Procedure 7550	Sequestrectomy for osteomyelitis or bone abscess, superficial.
Procedure 7970	Excision of hyperplastic tissue, per arch: A benefit when inflammatory hyperplastic tissue interferes with normal use of function of a prosthetic appliance.
Procedure 7971	Excision pericoronal gingiva, operculectomy.

I. ADJUNCTIVE GENERAL SERVICES

Must be pre-authorized. Claim must be accompanied by documentation from primary care physician as to the medical necessity.

1. General anesthesia as used for dental pain control means the elimination of all sensation accompanied by a state of unconsciousness.

2. Office (outpatient) general anesthesia may be payable when the provider indicates local anesthesia is contraindicated.

Procedure 9110	Emergency treatment, palliative, per visit.
Procedure 9220	General anesthesia – first thirty (30) minutes.

Procedure 9221	General anesthesia – each additional 15 minutes.
Procedure 9430	Office visit during regular office hours for treatment and/or observation of teeth and supporting structures.
Procedure 9440	Professional visit after regular office hours or to bedside.
Procedure 9930	Post-operative visit, complications (post surgical *e.g.*, osteitis).
Procedure 9940	Occlusal guard, by report.
Procedure 9951	Occlusal adjustment – limited.
Procedure 9952	Occlusal adjustment – complete.

J. UNLISTED PROCEDURES

Procedure 9999	Unlisted procedures; requires definition and requires prior authorization by County for non-emergency procedures..

VIII. NOT COVERED PROCEDURES

The following are not benefits under the program:

A. DIAGNOSTIC and PREVENTIVE

1. Preventive control program, including fissure sealant, prophylactic fillings, oral hygiene instruction, dietary instruction and prophylaxis when not in conjunction with restorative treatment. (Prophy's can be obtained at Sacramento City College Dental Hygiene Department).

B. ORAL SURGERY

1. Experimental procedures.
2. Asymptomatic extractions.
3. Surgical correction of the maxilla and mandible by grafts for denture retention.
4. Surgical treatment of temporomandibular joint disturbances.
5. Surgical treatment of prognathism or retrognathism.
6. Surgical treatment to correct congenital or developmental malformation.

C. PRESCRIBED DRUGS – Reimbursement for prescription drugs is not covered unless there is no other payor source and is limited to only those drugs that are currently prescribed by the dental community for dental related needs.

D. ORTHODONTIC SERVICES

E. RESTORATIVE DENTISTRY

1. Full mouth reconstruction procedure.
2. Cosmetic procedure and restorations (other than those for replacement of structure loss from caries) that are necessary to alter, restore or maintain occlusion. These include:
   a. Increasing vertical dimension.
   b. Replacing or stabilizing tooth structure loss by attrition.

c. Realignment of teeth.

d. Periodontal splinting.

e. Gnathologic recordings.

f. Equilibration.

g. Surgical treatment of disturbances of temporomandibular joint.

h. Services for the surgical treatment of prognathism or retrognathism.

3. Treatment of incipient or non-active caries as demonstrated radiographically.

F. PROSTHETICS

The program provides for replacement of missing teeth with full dentures or partials using standard procedures, when "medically necessary" by the dentist. A service is "medically necessary" or is a "medical necessity" when it is reasonable to protect life, to prevent significant illness or significant disability, or to alleviate sever pain.

Medically necessary dentures or partials must be preauthorized and are limited to once in a five (5) year period, unless rendered totally unfunctionable and not repairable.

Treatment involving the following is not covered:

- Specialized techniques
- Precious metal for removable appliances
- Overlays, implants and associated appliances
- Personalization or characterization

COUNTY OF SACRAMENTO **COST REIMBURSEMENT AGREEMENT NO. 7275-07/12-709 A4**

ATTACHMENT B AMENDMENT 4

Fee Schedule FY 2007-FY2012

CODE	DESCRIPTION	UOS	FEE
00110	Initial oral examination	0.4	$46.00
00120	Periodic oral examination	0.3	$34.50
00210	Intraoral-complete series (including bitewings)	0.7	$80.50
00220	Intraoral-periapical-first film	0.2	$23.00
00230	Intraoral-periapical-each additional film	0.1	$11.50
00240	Intraoral-occlusal film	0.3	$34.50
00270	Bitewing-single film	0.2	$23.00
00272	Bitewing-two films	0.3	$34.50
00274	Bitewing-four films	0.4	$46.00
00330	Panoramic film	0.6	$69.00
00470	Diagnostic casts	0.6	$69.00
01110	Prophylaxis-adult	0.6	$69.00
01120	Prophylaxis-child	0.5	$57.50
01201	Topical application of fluoride (including prophylaxis)-child	0.6	$69.00
01203	Topical application of fluoride (prophylaxis not included)-child	0.2	$23.00
01204	Topical application of fluoride (prophylaxis not included)-adult	0.3	$34.50
01205	Topical application of fluoride (including prophylaxis)-adult	0.7	$80.50
01351	Sealant-per tooth	0.3	$34.50
02110	Amalgam-one surface, primary	0.6	$69.00
02120	Amalgam-two surfaces, primary	0.7	$80.50
02130	Amalgam-three surfaces, primary	0.9	$103.50
02131	Amalgam-four or more surfaces, primary	1.0	$115.00
02140	Amalgam-one surface, permanent	0.7	$80.50
02150	Amalgam-two surfaces, permanent	0.9	$103.50
02160	Amalgam-three surfaces, permanent	1.0	$115.00
02161	Amalgam-four or more surfaces, permanent	1.2	$138.00
02330	Resin-one surface, anterior	0.9	$103.50
02331	Resin-two surfaces, anterior	1.0	$115.00
02332	Resin-three surfaces, anterior	1.2	$138.00
02335	Resin-four or more surfaces or involving incisal angle (anterior)	1.7	$195.50
02750	Crown-porcelain fused to high noble metal	7.8	$897.00
02751	Crown-porcelain fused to predominantly base metal	6.7	$770.50
02752	Crown-porcelain fused to noble metal	7.1	$816.50
02790	Crown-full cast high noble metal	7.0	$805.00
02791	Crown-full cast predominantly base metal	6.1	$701.50

05710	Rebase complete maxillary denture	3.4	$391.00
05711	Rebase complete mandibular denture	3.4	$391.00
05720	Rebase maxillary partial denture	3.4	$391.00
05721	Rebase mandibular partial denture	3.5	$402.50
05730	Reline complete maxillary denture (chairside)	1.7	$195.50
05731	Reline complete mandibular denture (chairside)	1.7	$195.50
05740	Reline maxillary partial denture (chairside)	1.7	$195.50
05741	Reline mandibular partial denture (chairside)	1.7	$195.50
05750	Reline complete maxillary denture (laboratory)	2.6	$299.00
05751	Reline complete mandibular denture (laboratory)	2.5	$287.50
05760	Reline maxillary partial denture (laboratory)	2.5	$287.50
05761	Reline mandibular partial denture (laboratory)	2.5	$287.50
05810	Interim complete denture (maxillary)	4.3	$494.50
05811	Interim complete denture (mandibular)	4.3	$494.50
05820	Interim partial denture (maxillary)	3.7	$425.50
05821	Interim partial denture (mandibular)	3.7	$425.50
05850	Tissue conditioning (maxillary)	1.0	$115.00
05851	Tissue conditioning (mandibular)	1.0	$115.00
06210	Pontic-cast high noble metal	7.0	$805.00
06211	Pontic-cast predominantly base metal	6.1	$701.50
06212	Ponic-cast noble metal	6.7	$770.50
06240	Pontic-porcelain fused to high noble metal	7.9	$908.50
06241	Pontic-porcelain fused to predominantly base metal	6.7	$770.50
06242	Pontic-porcelain fused to noble metal	7.0	$805.00
06750	Crown-porcelain fused to high noble metal	7.9	$908.50
06751	Crown-porcelain fused to predominantly base metal	6.6	$759.00
06752	Crown-porcelain fused to noble metal	7.0	$805.00
06790	Crown-full cast high noble metal	7.1	$816.50
06791	Crown-full cast predominantly base metal	6.3	$724.50
06792	Crown-full cast noble metal	7.0	$805.00
06930	Recement fixed partial denture	1.0	$115.00
06940	Stress breaker	2.6	$299.00
06970	Cast post and core in addition to fixed partial denture retainer	2.9	$333.50
06971	Cast post and core as part of a fixed partial denture retainer	2.9	$333.50
06972	Prefabricated post and core in addition to fixed partial denture retainer	2.3	$264.50
06973	Core build up for retainer, including any pins	1.8	$207.00
06980	Fixed partial denture repair, by report	5.5	$632.50
07110	Single tooth extraction	0.8	$92.00
07120	Each additional tooth extraction	0.8	$92.00
07130	Root removal-exposed roots	1.0	$115.00
07210	Surgical removal of erupted tooth requiring elevation of flap and/or removal of bone	1.3	$149.50
07220	Removal of impacted tooth-soft tissue	1.5	$172.50
07230	Removal of impacted tooth-partial bony	2.0	$230.00
07240	Removal of impacted tooth-complete bony	3.0	$345.00

07250	Surgical removal of residual tooth roots (cutting procedure)	1.4	$161.00
07285	Biopsy of oral tissue-hard	2.0	$230.00
07286	Biopsy of oral tissue-soft	1.5	$172.50
07310	Alveoloplasty in conjunction with extractions-per quadrant	1.3	$149.50
07311	Alveoloplasty not in conjunction with extractions-per quadrant	1.3	$149.50
07430	Excision of benign tumor-lesion diameter up to 1.25 cm	1.4	$161.00
07431	Excision of benign tumor-lesion diameter greater than 1.25 cm	2.0	$230.00
07440	Excision of malignant tumor-lesion diameter up to 1.25 cm	2.9	$333.50
07441	Excision of malignant tumor-lesion diameter greater than 1.25 cm	4.8	$552.00
07465	Destruction of lesion(s) by physical or chemical methods, by report	2.3	$264.50
07510	Incision and drainage of abscess-intraoral soft tissue	0.8	$92.00
07520	Incision and drainage of abscess-extraoral soft tissue	2.1	$241.50
07550	Sequestrectomy for osteomyelitis	2.9	$333.50
07970	Excision of hyperplastic tissue-per arch	2.3	$264.50
07971	Excision of pericoronal gingiva	0.9	$103.50
09110	Palliative (emergency) treatment of dental pain-minor procedure	0.7	$80.50
09430	Office visit for observation (during office hours, no other service performed)	0.4	$46.00
09440	Office visit after regularly scheduled hours	1.0	$115.00
09930	Treatment of complication (post surgical) unusual circumstances, by report	0.4	$46.00
09940	Occlusal guard, by report	3.8	$437.00
09951	Occlusal adjustment-limited	1.0	$115.00
09952	Occlusal adjustment-complete	3.8	$437.00
09999	Unspecified adjunctive procedure, by report		$0.00

EXHIBIT A-1 AMENDMENT 4 to Agreement between the COUNTY OF SACRAMENTO, hereinafter referred to as "COUNTY", and EL DORADO COUNTY HEALTH SERVICES DEPARTMENT - PUBLIC HEALTH DIVISION, hereinafter referred to as "CONTRACTOR"

SCOPE OF SERVICES: AMBULATORY/OUTPATIENT MEDICAL CARE

I. PROJECT DESCRIPTION

A. **Type of Program:** CONTRACTOR will provide Ambulatory/Outpatient Medical Care to People Living with HIV/AIDS (PLWH/A). Contractor will provide comprehensive high quality, client-centered, timely and cost-effective outpatient primary medical services to HIV-infected persons at all stages of disease.

B. **Length of Treatment:** Discharge from Ambulatory/Outpatient Medical Care will terminate upon the client's voluntary departure, death, or by termination on the part of CONTRACTOR from its owned or operated treatment facility. Termination will only be used as a last resort. Alternatives to termination, including conflict resolution and mediation, will be sought. Behavior that is threatening, violent, or endangers self or others will not be tolerated and shall be grounds for termination from the program.

C. **Population:** HIV-infected adults residing in the Sacramento Transitional Grant Area (TGA) which encompasses Sacramento, El Dorado and Placer Counties, who meet the Ryan White CARE Program eligibility guidelines.

II. SERVICES

A. CONTRACTOR will maintain and enhance individual health care by providing Ambulatory/Outpatient Medical Services to adults living with HIV/AIDS in Sacramento TGA. CONTRACTOR shall establish and implement policies and procedures which:

1. Ensure that referred clients receive timely, effective, and quality Ambulatory/Outpatient Medical Care that meets his/her special needs.

2. Incorporates and ensures compliance of ethical standards as established for all health care providers and legal standards as defined by federal and state governments regulating confidentiality (Civil Codes 38.1, 38.2, 38.3, Evidence Code 1012).

3. Incorporates and ensures, to the extent possible, adherence to established HIV clinical practice standards and the most current Public Health Services (PHS) guidelines for treatment and care of adult HIV+ persons.

B. CONTRACTOR will provide access to Ambulatory/Outpatient Medical Services for People Living with HIV/AIDS in the Sacramento TGA. Ambulatory/Outpatient Medical Services will include the following services:

1. Lab Visits.

2. Primary care visits with a HIV health care provider.

3. Specialty care visits with other medical specialist health care providers.

4. Medication adherence sessions as part of medical visits.

C. CONTRACTOR shall maintain an individualized medical file for each client, which contains documentation of all services provided, appropriate signed release of information forms and case notes documenting client contact and resource and referral follow-up.

D. CONTRACTOR shall use best efforts to achieve the outcomes described in sections 2 to 7 below and provide the levels of service delivery as follows:

1. Number of Unduplicated Clients:

a) A minimum of 21 clients will receive Ambulatory/Outpatient Medical Services during Fiscal Year 2007-2008.

b) A minimum of 24 clients will receive Ambulatory/Outpatient Medical Services during Fiscal Year 2008-2009.

c) A minimum of 20 clients will receive Ambulatory/Outpatient Medical Services during Fiscal Year 2009-2010.

d) A minimum of 134 clients will receive Ambulatory/Outpatient Medical Services during Fiscal Year 2010-2011.

e) A minimum of 134 clients will receive Ambulatory/Outpatient Medical Services during Fiscal Year 2011-2012.

2. Number of Units of Service:

a) Primary Care Visit:

(1) A minimum of 1 unit of service per client and an overall maximum of 5,500 units of service will be provided during Fiscal Year 2007-2008.

(2) A minimum of 1 unit of service per client and an overall maximum of 4,210.00 units of service will be provided during Fiscal Year 2008-2009.

(3) A minimum of 1 unit of service per client and an overall maximum of 3,300.00 units of service will be provided during Fiscal Year 2009-2010.

(4) A minimum of 1 unit of service per client and an overall maximum of 4,691.82 units of service will be provided during Fiscal Year 2010-2011.

(5) A minimum of 1 unit of service per client and an overall maximum of 4,691.82 units of service will be provided during Fiscal Year 2011-2012.

b) Lab Visit:

(1) A minimum of 1 unit of service per client and an overall maximum of 302.73 units of service will be provided during Fiscal Year 2007-2008.

(2) A minimum of 1 unit of service per client and an overall maximum of 429.32 units of service will be provided during Fiscal Year 2008-2009.

(3) A minimum of 1 unit of service per client and an overall maximum of 1,049.051 units of service will be provided during Fiscal Year 2009-2010.

(4) A minimum of 1 unit of service per client and an overall maximum of 478.18 units of service will be provided during Fiscal Year 2010-2011.

(5) A minimum of 1 unit of service per client and an overall maximum of 478.18 units of service will be provided during Fiscal Year 2011-2012.

c) Specialty Care Visit:

(1) A minimum of 1 unit of service per client and an overall maximum of 121.82 units of service will be provided during Fiscal Year 2007-2008.

(2) A minimum of 1 unit of service per client and an overall maximum of 100.00 units of service will be provided during Fiscal Year 2008-2009.

(3) Fiscal Year 2009-2010: Not Applicable.

(4) A minimum of 1 unit of service per client and an overall maximum of 109.09 units of service will be provided during Fiscal Year 2010-2011.

(5) A minimum of 1 unit of service per client and an overall maximum of 109.09 units of service will be provided during Fiscal Year 2011-2012.

1 unit of service – 1 vendor paid dollar for primary care visit with Health Care Provider OR

1 vendor paid dollar for lab visit OR

1 vendor paid dollar for specialty care visit with Health Care Provider

3. Documentation of on-going medical care will be charted in case files for 100% of clients.
4. The number of Hospital admissions as a ratio of the annual unduplicated caseload will be tracked and trended.
5. The number of emergency room visits as a ratio of the annual unduplicated caseload will be tracked and trended.
6. CD4 Counts and Viral Load counts as a ratio of the annual unduplicated caseload will be tracked and trended.
7. Death Rates per year as a percentage of annual unduplicated clients will be tracked and trended.
8. 70% of clients will receive a minimum of one primary care visit per year (12 month period).
9. CONTRACTOR shall document and track all service provision to clients through the SEMAS web-based database to identify clients who may withdraw from care.
10. CONTRACTOR will provide screening and treatment to 95% of clients reporting opportunistic infections who remain in care.
11. 60% of clients on HAART therapy will show improved or stable CD4 and viral load counts.
12. 100% of primary care services offered will meet Public Health Standard guidelines.

EXHIBIT A-2 AMENDMENT 4 to Agreement between the COUNTY OF SACRAMENTO, hereinafter referred to as "COUNTY", and EL DORADO COUNTY HEALTH SERVICES DEPARTMENT - PUBLIC HEALTH DIVISION, hereinafter referred to as "CONTRACTOR"

SCOPE OF SERVICES: MEDICAL CASE MANAGEMENT

I. PROJECT DESCRIPTION

A. **Type of Program:** CONTRACTOR will provide Medical Case Management services to HIV+ persons residing in the Sacramento Transitional Grant Area (TGA) which encompasses Sacramento, El Dorado and Placer Counties. The purpose of this program is to improve the overall health and well being of Persons Living with HIV/AIDS (PLWH/A) by ensuring that all the client's medical and psychosocial concerns are being adequately addressed within a case management system.

B. **Length of Treatment:** Discharge from Medical Case Management services will terminate upon the client's voluntary departure, death, or by termination on the part of CONTRACTOR. Termination will only be used as a last resort. Alternatives to termination, including conflict resolution and mediation, will be sought. Behavior that is threatening, violent, or endangers self or others will not be tolerated and shall be grounds for termination from the program.

C. **Population:** CONTRACTOR'S Medical Case Management program shall target HIV+ men, women, transsexuals, and children residing in the Sacramento TGA. All clients must meet the Ryan White CARE Program eligibility guidelines.

II. SERVICES

A. CONTRACTOR shall perform an intake process on each participant to evaluate client's suitability for CONTRACTOR's Medical Case Management Program. Clients who do not meet CONTRACTOR's eligibility criteria for Case Management will be referred to other providers that can meet their Medical Case Management needs. To be eligible for CONTRACTOR Medical Case Management Services, client must be an HIV+ person and must meet the Ryan White CARE Program eligibility guidelines.

B. CONTRACTOR'S Medical Case Management services will include but not be limited to a range of client-centered services that link clients with health care, psychosocial and other services to ensure timely, coordinated access to medically appropriate levels of health and support services, continuity of care, and ongoing assessment of the client's and other family members' needs and personal support systems. CONTRACTOR'S Medical Case Management services shall be operated in compliance with the Sacramento HIV Health Planning Council adopted "Standards of Care for Medical Case Management", as amended and found in CONTRACTOR's Ryan White Resource Manual. Medical Case Management will include, but not be limited to:

1. Intake Process: CONTRACTOR shall perform an intake process on each client meeting eligibility criteria for Medical Case Management services. The intake process will include determining eligibility for Ryan White-funded services, completing the Ryan White Intake Form, and providing the participant with an orientation to CONTRACTOR's program. CONTRACTOR'S providing field-based medical case management services will offer clients the opportunity to have the intake process completed in their home or at a site more accessible for the client than the CONTRACTOR'S regular place of business.

2. Evaluation and Assessment: During the initial intake process, CONTRACTOR shall perform an assessment of medical and psychosocial needs of the participant using the adopted TGA Medical Case Management Service Standards as a guide to determine appropriate service and/or resource referrals.

3. Care Plan: During the initial intake process, CONTRACTOR shall provide a face-to-face interview with participant to develop a comprehensive individualized Care Plan that prioritizes client needs, identifies resources necessary to meet those needs, and documents mutually agreed-upon goals. The specific number of case management sessions with the client will be tailored by the CONTRACTOR to an individual's needs based upon the results of an assessment and Care Plan. Care Plans shall be up-dated a minimum of once every six months.

4. Information and Referral: CONTRACTOR shall make referrals to the most appropriate resource to meet needs prioritized in the client's Case Plan. CONTRACTOR will document referrals and provide follow-up action to ensure that services are provided.

5. Case Files: CONTRACTOR shall maintain an individualized case file for each client which contains documentation of all services provided, appropriate signed release of information forms and case notes documenting client contact and resource and referral follow-up.

C. CONTRACTOR shall use best efforts to achieve the outcomes described in sections 3, 4, 5, 6, 7 and 8 below and provide the level of service delivery as follows:

1. Number of Unduplicated Clients:

a) A minimum of 1 and a maximum of 66 clients will receive medical case management services during Fiscal Year 2007-2008.

b) A minimum of 1 and a maximum of 150 clients will receive medical case management services during Fiscal Year 2008-2009.

c) A minimum of 1 and a maximum of 140 clients will receive medical case management services during Fiscal Year 2009-2010.

d) A minimum of 1 and a maximum of 119 clients will receive medical case management services during Fiscal Year 2010-2011.

e) A minimum of 1 and a maximum of 119 clients will receive medical case management services during Fiscal Year 2011-2012.

2. Number of Units of Service:

a) A minimum of 8 units of service per client and an overall maximum of 7,600.65 units of service will be provided not to exceed the total contract award during Fiscal Year 2007-2008.

b) A minimum of 8 units of service per client and an overall maximum of 9,214.00 units of service will be provided not to exceed the total contract award during Fiscal Year 2008-2009.

c) A minimum of 8 units of service per client and an overall maximum of 8027.56 units of service will be provided not to exceed the total contract award during Fiscal Year 2009-2010.

d) A minimum of 8 units of service per client and an overall maximum of 7,785.01 units of service will be provided not to exceed the total contract award during Fiscal Year 2010-2011.

e) A minimum of 8 units of service per client and an overall maximum of 7,785.01 units of service will be provided not to exceed the total contract award during Fiscal Year 2011-2012.

1 unit of service = 15 minutes of field based face-to-face encounter or 15 minutes of field based other encounter

3. 100% of participants will have had an assessment of medical and psychosocial needs, which determined appropriate resource referrals.

4. 100% of program participants will have a Plan of Care prioritizing needs and identifying goals to meet those needs.

5. 70% of unduplicated clients will maintain/achieve their individual care plan objectives as measured over twelve months.

6. Documentation of assistance provided will be charted in case files for 100% of clients.

7. 100% of participants will be reassessed at least once during the project year.

8. Documentation of on-going medical care will be charted in case files for 100% of clients.

9. CONTRACTOR will document and track all service provision to clients through the SEMAS web-based database in order to identify clients who may withdraw from care.

10. 100% of clients who do not have an identified primary care provider at intake will receive a referral to an appropriate physician or clinic.

11. 70% of clients receiving medical case management will maintain routine medical care (minimum three primary care visits per year that includes a CD4 count, viral load test or on ART).

EXHIBIT A-3 AMENDMENT 4 to Agreement between the COUNTY OF SACRAMENTO, hereinafter referred to as "COUNTY", and EL DORADO COUNTY HEALTH SERVICES DEPARTMENT - PUBLIC HEALTH DIVISION, hereinafter referred to as "CONTRACTOR"

SCOPE OF SERVICE: MENTAL HEALTH TREATMENT SERVICES

I. PROJECT DESCRIPTION

A. **Type of Services:** CONTRACTOR shall provide outpatient mental health services to HIV+ adults, their family members and caregivers who meet the eligibility requirements for the Sacramento Transitional Grant Area (TGA) Ryan White CARE Program. Outpatient mental health services include crisis intervention sessions, individual evaluation and assessment sessions, and individual counseling sessions.

B. **Goal:** Desired outcome is to maintain adults in the lowest level of mental health care possible while improving their ability to enter into and remain in medical care.

C. **Population:** Women living with HIV/AIDS in the Sacramento TGA with a primary focus on those persons who receive and/or enter and remain in primary medical care for their HIV/AIDS related condition(s). Family members, significant others and caregivers of women with HIV are also eligible to receive mental health services.

D. **Length of Treatment:** The length/duration of specialized mental health services shall be determined by the individualized needs of each client in accordance with his/her Plan of Care. There are no minimum/maximum levels or amounts of mental health services required. However, CONTRACTOR shall provide clinically appropriate levels of mental health services in accordance with Title IX of the California Code of Regulations and shall strive to maintain and/or improve the client's well being, stability in the community, and reduce the need for inpatient hospitalization.

II. SERVICES

A. CONTRACTOR shall establish and implement policies and procedures which:

1. Ensure that referred clients receive timely, effective, and quality mental health services that meet his/her special needs.

2. Incorporate and ensure compliance of ethical standards as established by all mental health disciplines (e.g. social workers, counselors, psychologists) and legal standards as defined by federal and state governments regulating confidentiality (Civil Codes 38.1, 38.2, 38.3, Evidence Code 1012).

B. CONTRACTOR shall provide individualized therapeutic interventions that address the presenting problem and mental health diagnosis of the referred client as evidenced by client chart documentation and internal utilization review.

C. CONTRACTOR shall establish and implement clinical oversight and monitoring systems which:

1. Address treatment issues, discharge planning, and scope of practice.

2. Ensure that client cases and documentation of cases are opened and closed in a timely and appropriate manner.

3. Include regular internal utilization review meetings by which charts/documentation of referred clients are thoroughly reviewed by agency staff.

D. CONTRACTOR shall ensure quality care by providing agency staff with on-going training and supervision.

E. CONTRACTOR shall develop Plans of Care which, as evidenced by client chart documentation and internal utilization review:

1. Meet the individualized needs of the referred client.

2. Address client's presenting issues and mental health diagnosis

3. Include client involvement.

F. CONTRACTOR shall provide referral and linkages to other county and community based services when clinically appropriate.

G. CONTRACTOR shall ensure interagency coordination, communication, and/or collaboration of services with other agencies with which the referred client is involved as evidenced by client chart documentation and internal utilization review.

H. CONTRACTOR shall provide appropriate referral and linkage for clients who do not meet criteria, are transitioning out of services, or require services beyond the scope of the contracted program.

I. CONTRACTOR shall demonstrate program effectiveness through performance outcomes.

J. CONTRACTOR shall provide culturally competent services by:

1. Seeking staff that provides multi-cultural representation on all levels.

2. Providing services to referred clients in a manner that is sensitive and responsive to racial, ethnic, linguistic, and cultural differences as evidenced by client chart documentation and internal utilization review.

K. CONTRACTOR shall provide services at hours that are convenient and acceptable to the referred client.

III. SERVICE DELIVERY REQUIREMENTS

A. Service Eligibility: CONTRACTOR shall perform an intake process on each participant seeking Ryan White-funded mental health services. The intake process will include determining eligibility for Ryan White-funded services, completing the Ryan White Intake Form, and providing the participant with an orientation to CONTRACTOR's program. The Intake process should be conducted within a maximum of 30 days of initial client contact, unless the agency can no longer accept clients as a result of a lack of funding or available staff. Clients placed on a waiting list must be provided with referrals to alternate available Ryan White Case Management agencies, and all waiting lists must be reported to the Ryan White Fiscal Agent. Once funding or staff becomes available, clients placed on the waiting list should be seen in order of need.

B. Service Eligibility for Non-Infected Clients: Non-infected individuals may be appropriate candidates for CARE Act services in limited situations, but these services must always have at least indirect benefit to a person with HIV. The Sacramento TGA's adopted Mental Health Service Standards outline these limited circumstances.

C. Evaluation and Assessment: During the initial intake process, CONTRACTOR shall perform an assessment of medical and psychosocial needs of the participant using the adopted TGA Case Management Service Standards as a guide to determine appropriate service and/or resource referrals.

D. CONTRACTOR shall document assessments, client plans, and progress notes, which accurately represent the mental health service provided and client progress.

E. CONTRACTOR shall meet all Ryan White program-staffing requirements. Staff clinicians who provide the services must meet all licensure and certification requirements as established by the State of California, Board of Behavioral Sciences. Registered interns may provide services if they have appropriate supervision by mental health professionals licensed within the State of California to provide mental health services and are employed directly by the applicant organization. It is understood that clinicians knowledgeable of HIV+ client needs will provide mental health services.

F. CONTRACTOR will document and track all service provision to clients through the SEMAS web-based database in order to identify clients who may withdraw from care.

G. CONTRACTOR shall use best efforts to achieve the outcomes described in sections 3, 4, 5, 6, 7 and 8 below and provide the level of service delivery as follows:

1. Number of Unduplicated Clients:

a) A minimum of 1 adult will receive individual psychological counseling services during Fiscal Year 2007-2008.

b) A minimum of 2 adults will receive individual psychological counseling services during Fiscal Year 2008-2009.

c) A minimum of 1 adult will receive individual psychological counseling services during Fiscal Year 2009-2010.

d) A minimum of 2 adults will receive individual psychological counseling services during Fiscal Year 2010-2011.

e) A minimum of 2 adults will receive individual psychological counseling services during Fiscal Year 2011-2012.

2. Number of Units of Service:

a) A maximum of 459.09 units of service will be provided at the maximum billing rate during Fiscal Year 2007-2008.

b) A maximum of 1,584.00 units of service will be provided at the maximum billing rate during Fiscal Year 2008-2009.

c) A maximum of 969.00 units of service will be provided at the maximum billing rate during Fiscal Year 2009-2010.

d) A maximum of 1,764.55 units of service will be provided at the maximum billing rate during Fiscal Year 2010-2011.

e) A maximum of 1,764.55 units of service will be provided at the maximum billing rate during Fiscal Year 2011-2012.

1 unit of service = 1vendor paid dollar for individual psychological counseling session

3. 100% of participants will have completed a pre-survey prior to or on their first mental health appointment at the agency or if the person is a continuing client they will have completed a pre-survey on their first appointment of each C.A.R.E. Program fiscal year commencing March 1.

4. 100% of participants will have completed a post-survey at the time they complete treatment at the agency or at the end of each C.A.R.E. Program fiscal year on February 28, whichever event comes first.

5. 100% of long-term ongoing clients will have completed a post-survey one-year after they began receiving treatment at the agency and again each year following to track the progress of treatment.

6. 100% of client survey responses will be reported to the Sacramento TGA Ryan White CARE Program.

7. 100% of clients who do not have an identified primary care provider at the time of Intake will receive a referral and access an appropriate physician or clinic during the program year.

8. 60% of HIV+ clients who receive mental health services will report increased functionality within 90 days of start of treatment.

EXHIBIT A-4 AMENDMENT 4 to Agreement between the COUNTY OF SACRAMENTO, hereinafter referred to as "COUNTY", and EL DORADO COUNTY HEALTH SERVICES DEPARTMENT - PUBLIC HEALTH DIVISION, hereinafter referred to as "CONTRACTOR"

SCOPE OF SERVICES: SUPPORT SERVICE - MEDICAL TRANSPORTATION

I. PROJECT DESCRIPTION

A. **Type of Service:** CONTRACTOR will provide Support Services in the form of Medical Transportation to Persons Living with HIV/AIDS (PLWH/A). Many PLWH/A have multiple needs because of the numerous logistical barriers to accessing care and/or staying in care, including, but not limited to: poverty, isolation, trust of government systems, homelessness, mental health (including multiple diagnoses), ability to pay for medical services, and discrimination. Support Services – Medical Transportation shall provide assistance to promote quality of life and remove major barriers that prevent PLWH/A from accessing needed primary medical care.

B. **Population:** Persons living with HIV/AIDS in the Sacramento Transitional Grant Area (TGA), which encompasses El Dorado, Placer, and Sacramento Counties, with a primary focus on those persons who receive and/or enter and remain in primary medical care for their HIV/AIDS related condition(s).

C. **Goal:** Desired outcome is to provide basic Support Services - Medical Transportation to persons living with HIV/AIDS in the Sacramento TGA and to improve their ability to enter into and/or remain in primary medical care.

II. SERVICES

A. CONTRACTOR will maintain and enhance individual health care by providing Support Services to PLWH/A in the Sacramento TGA. CONTRACTOR shall establish and implement policies and procedures that ensure the referred client receives timely, effective, and quality Support Services - Medical Transportation that meet their individual needs as determined by a Plan of Care developed by a Sacramento TGA medical case management agency that is Ryan White CARE Program funded. Exceptions: clients receiving volunteer-based Transportation Services, Buddy/Companion Services, Peer/Support Groups and/or Service Outreach/Case Funding, do not require case management participation.

B. CONTRACTOR shall ensure Support Services – Medical Transportation are designed as coordinated services to facilitate access to primary medical care and to promote continuity of care. It is the intent of these services to improve the quality of life of persons living with HIV/AIDS in the Sacramento TGA.

C. CONTRACTOR shall perform an intake process for each client meeting eligibility criteria for Medical Transportation Support Services. The intake process will include determining eligibility for Ryan White-funded services, completing the Ryan White Intake Form, and providing the participant with an orientation to the Support Services CONTRACTOR provides. The Intake process should be conducted within a maximum of 30 days of initial client contact, unless the agency can no longer accept clients as a result of a lack of funding or available staff. Clients placed on a waiting list must be provided with referrals to alternate available Ryan White Medical Case Management agencies, and all waiting lists must be reported to the Ryan White Fiscal Agent. Once funding or staff becomes available, clients placed on the waiting list should be seen in order of need.

D. CONTRACTOR shall make referrals to the most appropriate resources to meet the needs prioritized in the client's Plan of Care, will document referrals and provide follow-up action to ensure that referred services were/are provided.

E. CONTRACTOR shall provide a minimum level of service delivery as follows:

1. **SS-Medical Transportation:** Conveyance services provided to a client in order to access medical care or HIV-related psychosocial services and medical transportation to basic local, state, and federal entitlement program facility sites within the TGA only. Conveyance may be provided through joint-agency arrangement for volunteer-based transportation services, routinely or on an emergency basis via bus passes, or as a last resort, and clearly documented as an immediate need, taxicab services through an appropriate vendor.

2. Unduplicated Clients:

a) A minimum of 15 clients will receive transportation assistance during Fiscal Year 2007-2008.
b) A minimum of 35 clients will receive transportation assistance during Fiscal Year 2008-2009.
c) A minimum of 32 clients will receive transportation assistance during Fiscal Year 2009-2010.
d) A minimum of 42 clients will receive transportation assistance during Fiscal Year 2010-2011.
e) A minimum of 42 clients will receive transportation assistance during Fiscal Year 2011-2012.

3. Units of Service:

a) A maximum of 1,811.82 units of service will be provided at the maximum billing rate during Fiscal Year 2007-2008.

b) A maximum of 3,177.69 units of service will be provided at the maximum billing rate during Fiscal Year 2008-2009.

c) A maximum of 2,714.50 units of service will be provided at the maximum billing rate during Fiscal Year 2009-2010.

d) A maximum of 3,540.91 units of service will be provided at the maximum billing rate during Fiscal Year 2010-2011.

e) A maximum of 3,540.91 units of service will be provided at the maximum billing rate during Fiscal Year 2011-2012.

1 unit of service = 1 vendor paid transportation dollar

III. INTENDED OUTCOMES

A. CONTRACTOR shall strive to achieve the minimum and maximum service deliveries as described in Section II listed above.

B. CONTRACTOR shall ensure documentation of intake process be charted in case files for 100% of clients.

C. CONTRACTOR shall ensure that 100% of program participants have a Plan of Care developed by a Sacramento TGA Ryan White CARE Program funded case management agency. Exceptions: clients receiving Volunteer-based Transportation Services, Buddy/Companion Services, and/or Service Outreach/Case Finding, which do not require case management participation.

D. CONTRACTOR shall offer 100% of participants an array of transportation service options to overcome barriers to accessing primary medical care.

E. CONTRACTOR shall document and track all service provision to clients through the SEMAS web-based database to identify clients who may withdraw from care.

F. CONTRACTOR shall ensure documentation of on-going medical care will be charted in case files for 100% of clients.

G. CONTRACTOR shall document all other resources available to client and other private and community resources attempted and/or accessed prior to using Ryan White CARE Act funds (i.e. payer of last resort).

H. 70% of Medical Transportation clients will maintain routine medical care (minimum three primary care visits per year that includes a CD4 count, viral load or on ART).

I. 75% of clients showing evidence of need for medical transportation services will receive transportation for HIV/AIDS related care appointments.

EXHIBIT A-5 AMENDMENT 4 to Agreement
between the COUNTY OF SACRAMENTO,
hereinafter referred to as "COUNTY", and
EL DORADO COUNTY HEALTH SERVICES DEPARTMENT - PUBLIC HEALTH DIVISION,
hereinafter referred to as "CONTRACTOR"

SCOPE OF SERVICES: EMERGENCY FINANCIAL ASSISTANCE

I. PROJECT DESCRIPTION

A. **Type of Service**: CONTRACTOR will provide Emergency Financial Assistance to Persons Living with HIV/AIDS (PLWH/A). Many PLWH/A have multiple needs because of the numerous logistical barriers to accessing care and/or staying in care, including, but not limited to: poverty, isolation, trust of government systems, homelessness, mental health (including multiple diagnoses), ability to pay for medical services, and discrimination. Support Services shall provide assistance to promote quality of life and remove major barriers that prevent PLWH/A from accessing needed primary medical care..

B. **Population**: Persons living with HIV/AIDS in the Sacramento Transitional Grant Area (TGA), which encompasses El Dorado, Placer, and Sacramento Counties, with a primary focus on those persons who receive and/or enter and remain in primary medical care for their HIV/AIDS related condition(s).

C. **Goal:** Desired outcome is to provide basic Emergency Financial Assistance to persons living with HIV/AIDS in the Sacramento TGA and to improve their ability to enter into and/or remain in primary medical care.

II. SERVICES

A. CONTRACTOR will maintain and enhance individual health care by providing Emergency Financial Assistance to PLWH/A in the Sacramento TGA. CONTRACTOR shall establish and implement policies and procedures that ensure the referred client receives timely and effective Emergency Financial Assistance that meets their individual needs as determined by a Plan of Care developed by a Sacramento TGA case management agency that is Ryan White CARE Program funded.

B. CONTRACTOR shall ensure Emergency Financial Assistance is designed as a coordinated service to facilitate access to primary medical care and to promote continuity of care. It is the intent of these services to improve the quality of life of persons living with HIV/AIDS in the Sacramento TGA.

C. CONTRACTOR shall perform an intake process for each client meeting eligibility criteria for Emergency Financial Assistance. The intake process will include determining eligibility for Ryan White-funded services, completing the Ryan White Intake Form, and providing the participant with an orientation to the Emergency Financial Assistance CONTRACTOR provides. The Intake process should be conducted within a maximum of 30 days of initial client contact, unless the agency can no longer accept clients as a result of a lack of funding or available staff. Clients placed on a waiting list must be provided with referrals to alternate available Ryan White Case Management agencies, and all waiting lists must be reported to the Ryan White Fiscal Agent. Once funding or staff becomes available, clients placed on the waiting list should be seen in order of need.

D. CONTRACTOR shall make referrals to the most appropriate resources to meet the needs prioritized in the client's Plan of Care, will document referrals and provide follow-up action to ensure that referred services were/are provided.

E. CONTRACTOR shall provide a minimum level of service delivery as follows:

Other Critical Needs: Services developed to meet the needs of clients not listed in other support service categories, such as short-term direct emergency financial assistance for health insurance premiums and other critical needs. Payment on behalf of client shall be made to the provider of said assistance or need directly. Ryan White CARE Program-funded clients shall not receive any direct financial assistance payments.

A. Unduplicated Clients:

1) A minimum of 32 clients will receive emergency financial assistance for other critical needs during Fiscal Year 2007-2008.

2) A minimum of 46 clients will receive emergency financial assistance for other critical needs during Fiscal Year 2008-2009.

3) A minimum of 43 clients will receive emergency financial assistance for other critical needs during Fiscal Year 2009-2010.

4) A minimum of 48 clients will receive emergency financial assistance for other critical needs during Fiscal Year 2010-2011.

5) A minimum of 48 clients will receive emergency financial assistance for other critical needs during Fiscal Year 2011-2012.

B. Units of Service:

1) A maximum of 15,341.82 units of service will be provided at the maximum billing rate during Fiscal Year 2007-2008.

2) A maximum of 8,751.20 units of service will be provided at the maximum billing rate during Fiscal Year 2008-2009.

3) A maximum of 8,693.56 units of service will be provided at the maximum billing rate during Fiscal Year 2009-2010.

4) A maximum of 9,752.73 units of service will be provided at the maximum billing rate during Fiscal Year 2010-2011.

5) A maximum of 9,752.73 units of service will be provided at the maximum billing rate during Fiscal Year 2011-2012.

1 unit of service = 1 vendor paid food dollar

III. INTENDED OUTCOMES

A. CONTRACTOR shall strive to achieve the minimum and maximum service deliveries as described in Section II listed above.

B. CONTRACTOR shall ensure documentation of intake process be charted in case files for 100% of clients.

C. CONTRACTOR shall ensure that 100% of program participants have a Plan of Care developed by a Sacramento TGA Ryan White CARE Program funded case management agency.

D. CONTRACTOR shall offer 100% of participants emergency financial assistance to overcome barriers to accessing primary medical care.

E. CONTRACTOR shall document in individualized case file for 100% of clients: Proof of need and payment (e.g. copy of utility/telephone cut-off notice/bill, vendor invoice, etc.); appropriate signed release of information forms; all contact with client; resource referrals; and case notes.

F. CONTRACTOR shall document all other resources available to client and other private and community resources attempted and/or accessed prior to using Ryan White CARE Act funds (i.e. payor of last resort)

G. CONTRACTOR shall document and track all service provision to clients through the SEMAS web-based database to identify clients who may withdraw from care.

H. Documentation of on-going medical care will be charted in case files for 100% of clients.

I. 70% of clients accessing Emergency Financial Assistance will continue to access routine medical care (Minimum three primary care visits per year that includes a CD4 count, viral load test or on ART).

J. CONTRACT shall adhere to service standards and directives as determined by the HIV Health Services Planning Council.

COUNTY OF SACRAMENTO **COST REIMBURSEMENT AGREEMENT NO. 7275-07/12-709 A4**

EXHIBIT A-6 AMENDMENT 4 to Agreement
between the COUNTY OF SACRAMENTO,
hereinafter referred to as "COUNTY", and
EL DORADO COUNTY HEALTH SERVICES DEPARTMENT - PUBLIC HEALTH DIVISION,
hereinafter referred to as "CONTRACTOR"

SCOPE OF SERVICES: ORAL HEALTH CARE

I. PROJECT DESCRIPTION

A. **Type of Program:** CONTRACTOR will provide Oral Health Care to People Living with HIV/AIDS (PLWH). Under the Oral Health Care Program the CONTRACTOR will provide the following services: diagnostic, prophylactic and therapeutic services rendered by licensed dentists, dental hygienists, dental assistants and other appropriately licensed or certified professional practitioners.

B. **Length of Treatment:** Length of treatment will be determined based on the diagnostic assessment by a licensed dentist of emergency Oral Health Care required and authorized under the current adopted Ryan White HIV Dental Program Operations Manual attached as Attachment A.

C. **Population:** HIV infected persons in the Sacramento TGA with a primary focus on persons who need improvement in dental health.

II. SERVICES

A. CONTRACTOR will maintain and enhance individual health care by providing Oral Health Care to People Living with HIV/AIDS in the Sacramento TGA.

1. CONTRACTOR shall establish and implement policies and procedures that ensure that referred clients receive timely, effective, and quality Oral Health Care that meets his/her special needs.

2. CONTRACTOR shall establish and implement policies and procedures that incorporate and ensure compliance of ethical standards as established for all health care providers and legal standards as defined by federal and state governments regulating confidentiality (Civil Codes 38.1, 38.2, 38.3, Evidence Code 1012).

3. CONTRACTOR will provide access to Oral Health Care for People Living with HIV/AIDS in the Sacramento TGA. Oral Health Care will be limited to the services listed in the Sacramento County- Units of Services (UOS) Schedule 2007/2010 attached as Attachment B.

4. CONTRACTOR shall perform an intake process on each client meeting eligibility criteria for Oral Health Care services. The intake process will include determining eligibility for Ryan White-funded services, completing the Ryan White Intake Form, and providing the participant with an orientation to the CONTRACTOR'S SERVICE PROGRAM. The Intake process should be conducted within a maximum of 30 days of initial client contact, unless the agency can no longer accept clients as a result of a lack of funding or available staff. Clients placed on a waiting list must be provided with referrals to alternate available Ryan White Medical Case Management agencies, and all waiting lists must be reported to the Ryan White Fiscal Agent. Once funding or staff becomes available, clients placed on the waiting list should be seen in order of need.

5. Documentation of on-going dental care will be charted in case files for 100% of clients.

6. CONTRACTOR shall document and track all service provision to clients through the SEMAS web-based database to identify clients who may withdraw from care.

7. CONTRACTOR shall use best efforts to achieve the outcomes described in sections a. through d. below:

a. The number of clients who receive actual definitive or emergency treatment will measure the improvement in dental health. Persons who receive diagnostic services, and who do not return for preventative or restorative services, will not be considered as having an improvement in their dental health. Persons who receive any type of definitive therapy, including emergency care for the relief of pain or infection, will have been considered to have benefited or experienced an improvement in their dental health.
b. To implement a client satisfaction survey to monitor the perception of quality through the consumer's perspective. This survey will be done once per year according to a schedule determined by the Ryan White CARE program.
c. Documentation of on-going dental care will be charted in case files for 100% of clients.
d. CONTRACTOR shall document and track all service provision to clients through the SEMAS web-based database to identify clients who may withdraw from care.

B. CONTRACTOR shall provide the level of service delivery as follows:
1. Number of Unduplicated Clients:
i. A minimum of 1 client and a maximum of 2 clients will receive Oral Health Care during Fiscal Year 2007-2008.
ii. A maximum of 5 clients will receive Oral Health Care during Fiscal Year 2008-2009.
iii. A maximum of 2 clients will receive Oral Health Care during Fiscal Year 2009-2010.
iv. A maximum of 2 clients will receive Oral Health Care during Fiscal Year 2010-2011.
v. A maximum of 2 clients will receive Oral Health Care during Fiscal Year 2011-2012.

2. Number of Units of Service:
i. A minimum of 1 unit of service per client and an overall maximum of 2,450.00 units of service will be provided at the maximum billing rate during Fiscal Year 2007-2008.
ii. A minimum of 1 unit of service per client and an overall maximum of 3,879.68 units of service will be provided at the maximum billing rate during Fiscal Year 2008-2009.
iii. A minimum of 1 unit of service per client and an overall maximum of 865.00 units of service will be provided at the maximum billing rate during Fiscal Year 2009-2010.
iv. A minimum of 1 unit of service per client and an overall maximum of 4,323.64 units of service will be provided at the maximum billing rate during Fiscal Year 2010-2011.
v. A minimum of 1 unit of service per client and an overall maximum of 4,323.64 units of service will be provided at the maximum billing rate during Fiscal Year 2011-2012.

1 unit of service = 1 vendor paid dollar for dental visit

3. 70% of dental clients will maintain routine medical care (minimum three primary care visits per year that includes a CD4 count, viral load or on ART).

4. 100% of dental clients who do not have an identified primary care provider at intake will receive a referral to an appropriate physician or clinic.

III. COUNTY RESIDENCY

Funding provided under Exhibit A-1 of this Agreement is for services to Sacramento, El Dorado and Placer County residents only. A person is a Sacramento, El Dorado or Placer County resident if he/she is currently staying in one of these counties with the intent to remain and live in one of the specified counties. Any person who comes to Sacramento, El Dorado or Placer County for the express purpose of qualifying to receive services from a COUNTY-funded program, and intends to leave the county after receipt of services, is not considered a resident. Proof of residency can be established by the following:

A. Any bill or correspondence current to within the previous two weeks showing the individual's name and a Sacramento, El Dorado or Placer County address.

B. Written statement by homeless shelter staff verifying that the individual has been in shelter residence in Sacramento, El Dorado or Placer County continuously for the previous two weeks.

C. Current state issued identification card reflecting a Sacramento, El Dorado or Placer County address.

D. Other reliable evidence that establishes Sacramento, El Dorado or Placer County residency.

ATTACHMENT A AMENDMENT 4

RYAN WHITE HIV DENTAL PROGRAM
OPERATIONS MANUAL

I. CRITERIA FOR DENTAL SERVICES UNDER THE PART A and SINGLE ALLOCATION METHOD (SAM) RYAN WHITE PROGRAM

This document is a compilation of criteria which apply to dental services. It is designated to provide assistance to dentists treating beneficiaries, in determining service authorization and payment. These criteria are designated to ensure that program funds are spent on services that are medically necessary and are in substantial compliance with the Ryan White HIV Dental Program Policy, and generally accepted standards of dental practice. However, these criteria are but guidelines with which to apply professional judgement in assuring that dental services are appropriate, necessary and of high quality. Professional judgement shall be applied in the determination of benefits and/or payment on the basis of these reliable and valid criteria, evaluation, and interpretation of diagnostic material. Providers and County consultants have established these criteria to standardize the exercise of professional judgement. However, it should be pointed out that this listing does not establish a requirement that consultants must authorize services which meet the criteria listed.

II. REASONABLE AND NECESSARY CONCEPT

A. Outpatient dental services which are reasonable and necessary for the diagnosis and treatment of dental disease, injury, or defect are covered.

B. The underlying principle of whether a service is reasonable and necessary is whether or not the requested service or item is in accord with generally accepted standards of dental practice and is indispensable to the oral health of the beneficiary. Treatment shall be granted or reimbursement made only for covered services appropriate to the present adverse condition which has been approved according to program requirements.

III. EMERGENCY DENTAL SERVICES

A. Within the scope of dental care benefits under the program, emergency dental services may comprise those diverse professional services required in the event of unforeseen medical conditions such as hemorrhage, infection, or trauma. Emergency service shall conform to acceptable standards within our community. Examples of emergency conditions may include, but are not limited to the following:

1. High risk-to life or minimally disabling conditions, *e.g.*, painful oral-dental infections, pulpal exposures, and fractured teeth.

B. Possible emergency dental treatment may include, but is not limited to: antibiotics administrations; prescriptions of analgesics or antibiotics; temporary or permanent filling; pulpal treatment, where sedative holding measures are not effective; biopsy; denture adjustment; treatment of evulsed teeth; control of post-operative bleeding; treatment for acute periodontitis.

IV. DENTIST PARTICIPATION INFORMATION

The fee payable to providers is at the negotiated rate, as stated in the provider's contracted fee schedule, for covered services.

V. PRIOR AUTHORIZATION

A. Prior authorization by a County representative may be required for dental services including but not limited to endodontic and periodontic treatment, cast partials, castings, dentures, and referrals to outside dental specialty providers (see covered services for specifics).

B. The cost of hospitalization is **not** covered. The dental procedures performed during hospitalization will be covered at the same rate specified in the provider's contracted fee schedule. No other hospital related costs are covered.

VI. UNLISTED PROCEDURES (9999)

A. Complete description of the proposed treatment and the need for service must be documented.

B. The fee requested must be listed and is subject to review by County representatives.

C. Non-emergency unlisted procedures require prior authorization.

VII. COVERED PROCEDURES

A. DIAGNOSTIC

Procedure 0110	Examination, initial episode of treatment only. Radiographs are covered when taken in compliance with state and federal regulations for radiation hygiene, and when they fully depict subject teeth and associated structures by standard illumination, and are appropriate to the symptoms and conditions of the patient.
Procedure 0120	Periodic oral examination limited to any two examinations (0110, 0120, 0130) per contract year.
Procedure 0210	Intraoral, complete series when medically necessary and in accepted standards of dental practice. Limited to once in a three (3) year period.
Procedure 0230	Intraoral periapical, each additional film (maximum ten films).
Procedure 0240	Intraoral, occlusal film.
Procedure 0272	Bitewings, two films. Limited to once per contract year.
Procedure 0274	Bitewings, four films. Limited to once per contract year.
Procedure 0330	Panographic-type film, single film. Limited to once every three (3) years.
Procedure 0470	Diagnostic casts.

B. PREVENTIVE – Covered only when in conjunction with restorative procedures and limited to two (2) times per contract year.

Procedure 1110	Prophylaxis – adult, limited to two (2) times per contract year.
Procedure 1120	Prophylaxis – child, limited to two (2) times per contract year.
Procedure 1201	Topical application of fluoride (including prophylaxis) – child.
Procedure 1203	Topical application of fluoride (prophylaxis not included) – child.
Procedure 1204	Topical application of fluoride (including prophylaxis) – adult.
Procedure 1205	Topical application of fluoride (prophylaxis not included) – adult.
Procedure 1351	Sealant – per tooth, children only.

C. RESTORATIVE DENTISTRY

1. The program provides temporary restoration, amalgam, composite, or plastic restorations for treatment of caries. If the tooth can be restored with such material, any crown or jacket is not covered.

2. Laboratory processed crowns are benefits for permanent anterior teeth and permanent posterior teeth once in a five (5) year period.

3. When a crown is placed on a posterior molar tooth, porcelain, resin and similar materials are optional. An allowance will be made based on the fee for a full metal crown.

4. Authorization may be granted for the lowest cost item or service that meets the patient's medical needs. When acting upon request for approval for laboratory processed crowns, these regulations as well as the overall condition of the mouth, patient's receptivity toward treatment and willingness to comply with maintaining good oral hygiene, oral health status, arch integrity, and prognosis of remaining teeth shall be considered.

5. Laboratory processed crowns may be granted where longevity is essential and a lesser service will not suffice, when extensive coronal destruction is radiographically demonstrated and treatment is beyond intercoronal restoration.

6. Cast or performed posts are covered for devitalized teeth only.

7. Laboratory process crowns on endodontically treated teeth are covered only after satisfactory completion of the root canal therapy.

Procedure 2110	Amalgam restoration, primary tooth, one surface.
Procedure 2120	Amalgam restoration primary tooth, two surfaces.
Procedure 2130	Amalgam restoration, primary tooth, three surfaces.
Procedure 2131	Amalgam restoration, primary tooth, four or more surfaces.
Procedure 2140	Amalgam restoration, permanent tooth, one surface.
Procedure 2150	Amalgam restoration, permanent tooth, two surfaces.
Procedure 2160	Amalgam restoration, permanent tooth, three surfaces.
Procedure 2161	Amalgam restoration, permanent tooth, four or more surfaces.
Procedure 2330	Composite restoration, one surface – anterior tooth.
Procedure 2331	Composite restoration, two surfaces – anterior tooth.
Procedure 2332	Composite restoration, three surfaces – anterior tooth.
Procedure 2335	Composite restoration, four or more surfaces or involving incisal angle – anterior.
Procedure 2750	Crown, porcelain fused to metal (anterior teeth only).
Procedure 2790	Crown, full case high noble metal.
Procedure 2910	Re-cement inlay, facing, pontic.
Procedure 2920	Re-cement crown.
Procedure 2930	Crown stainless steel, primary.
Procedure 2931	Crown stainless steel, permanent.
Procedure 2950	Core buildup, including any pins.
Procedure 2951	Pin retention (per pin), maximum three pins per tooth.

Procedure 2952 Cast post and core, in addition to crown.

Procedure 2954 Prefabricated post and core, in addition to crown.

Procedure 2970 Temporary crown or stainless steel band.

D. ENDODONTICS – GENERAL POLICIES

1. Includes those procedures when complete root canal filling on permanent teeth:

   a. Root canal therapy is a covered benefit, if medically necessary – tooth is non-vital. The prognosis of the affected tooth and other remaining teeth will be evaluated in considering root canal therapy.

   b. Authorization and payment for root canal treatment includes, but is not limited to, any of the following procedures:

      Any incision and drainage necessary on relation to the root canal therapy.

      Vitality test.

      Radiographs required during treatment.

      Culture.

      Medicated treatment.

      Final filling of canals.

      Final treatment radiographs.

   c. Necessary retreatment and postoperative care within a 90-day period is included in the reimbursement fee for the root canal therapy.

   d. Root canal therapy must be completed prior to payment. Date of service on the claim for payment must reflect the final completion date.

2. Emergency root canal treatment may be done when any of the following conditions exist and **documentation substantiates the need**:

   a. Failure of a palliative treatment to relieve the acute distress of the patient.

   b. When a tooth has been accidentally evulsed.

   c. When there has been a fracture of the crown of a tooth exposing the pulpal tissue.

3. The prognosis of the affected tooth, other remaining teeth, and the type of restorations allowable will be evaluated in considering requested root canal therapy.

4. Extraction may be suggested for a tooth with a fractured root, external or internal resorption, or one that is easily replaced by addition to an existing removable dental appliance.

Procedure 3110 Pulp cap – direct (excluding final restoration).

Procedure 3120 Pulp cap – indirect (excluding final restoration).

Procedure 3220 Therapeutic pulpotomy (excluding final restoration).

Procedure 3310 Anterior root canal therapy (excluding final restoration).

Procedure 3320 Bicuspid root canal therapy (excluding final restoration).

Procedure 3330 Molar root canal therapy (excluding final restoration).

Procedure 3410 Apicoectomy (separate surgical procedure) per tooth: This procedure when there is severe apical curvature, blockage of the canal by calcific deposits, dentinal shavings or pulp chamber debris, and when a canal wall has been perforated or "shelved" during canal enlargement.

E. PERIODONTICS

1. PERIODONTICS – GENERAL POLICIES

Accepted dental practice indicates that periodontal treatment should use therapeutic measures on an ordered schedule limited to the direct, least invasive measures necessary to achieve the result.

Procedure 4210 Gingivectomy or gingivoplasty – per quadrant.

Procedure 4211 Gingivectomy or gingivoplasty, treatment per tooth (fewer than six teeth): May be authorized when an isolated pocket has not responded to conservative treatment.

Procedure 4220 Gingival curettage, surgical, per quadrant, by report.

Procedure 4240 Gingival flap procedure, including root planning – per quadrant.

Procedure 4341 Subgingival curettage and root planning, per treatment: Root planing includes the removal of calculus deposits on the tooth and root, the smoothing of the root and surface; subgingival curettage – the removal of granulation tissue and pocket lining epithelium. Treatment is limited to those areas requiring immediate attention.

Procedure 4910 Periodontal maintenance procedures (following active therapy).

F. PROSTHETICS - REMOVABLE

1. Full dentures are covered when medically necessary using standard procedures which exclude precision attachments, implants or other specialized techniques. These services are covered only once in a five year period

   a. Prevent a significant disability.

   b. Replace a covered removable dental prosthesis which has been lost or destroyed due to circumstances beyond the beneficiary's control.

2. Request for the extraction of all remaining teeth in preparation for complete immediate dentures and the immediate full dentures following full mouth extractions (both anterior and posterior) is a covered benefit.

3. Construction of new dentures shall not be authorized if conditions including but not limited to the following exist:

   a. It would be impossible or highly improbable for a beneficiary to adjust to a new prosthetic appliance. This is particularly applicable in those cases where the patient has been without dentures for an extended period of time or where the beneficiary may exhibit a poor adaptability due to psychological and/or motor deficiencies.

   b. The dental history shows that any or all dentures made in recent years have been unsatisfactory for reasons that are not remediable (psychological).

   c. Repair, relining, or reconstruction of the recipient's present denture will make it serviceable.

d. The denture, in the patient's opinion only, is loose or ill-fitting but is recently enough constructed to indicate deficiencies limited to those inherent in all dentures.

e. Where the request for the denture(s) is primarily cosmetic, the authorization shall be denied.

f. The patient has been without dentures for at least five (5) years and is currently functioning without dentures.

4. Immediate dentures may be authorized when conditions including but not limited to the following exist:

a. Extensive or rampant caries are exhibited.

b. Severe periodontal involvement is indicated.

i. When the clinical exam shows excessive mobility and severe gingivitis.

ii. When tooth mobility is not grossly evident and when the gingival tissues are not severely involved, consideration should be given to a more conservative treatment and denture request denied.

c. Numerous teeth are missing and masticating ability has been diminished.

i. Where there is not capability of any posterior occlusion with existing dentition.

ii. When a functional, although minimal, occlusion exists, the urgent need for prosthesis should be carefully evaluated.

5. Requests for replacement dentures shall include adequate supportive documentation and shall be preauthorized. Replacement dentures may be authorized more often than once in a five (5) year period when:

a. Catastrophic loss of denture.

b. Surgical or traumatic loss of oral-facial anatomic structures.

c. Replacement of existing dentures.

i. When there has been a complete deterioration of the denture base or teeth.

ii. When there has been a complete loss of retentive ability, vertical dimension, or balanced occlusion of existing dentures.

6. Requests for dentures for the long-standing edentulous patient will be denied.

7. A removable Partial denture is covered when necessary for the replacement of anterior teeth only.

8. A covered removable partial denture may be authorized only once in a five (5) year period except to:

a. Prevent a significant disability.

b. Replace a covered removable dental prosthesis which has been lost or destroyed due to circumstances beyond the beneficiary's control.

Procedure 5110 Complete denture - maxillary.

Procedure 5120 Complete denture – mandibular.

Procedure 5130 Immediate denture – maxillary.

Procedure 5140 Immediate denture – mandibular.

Procedure 5211	Maxillary partial denture – resin base (including any conventional clasps, rests and teeth).
Procedure 5212	Mandibular partial denture – resin base (including any conventional clasps, rests and teeth).
Procedure 5213	Maxillary partial denture – predominantly base metal (including any conventional clasps, rests and teeth).
Procedure 5214	Mandibular partial denture – predominantly base metal (including any conventional clasps, rests and teeth).
Procedure 5410	Denture adjustment – maxillary denture.
Procedure 5411	Denture adjustment – mandibular denture.
Procedure 5421	Denture adjustment – maxillary partial.
Procedure 5422	Denture adjustment – mandibular partial.
Procedure 5510	Repair broken denture base only (complete or partial).
Procedure 5520	Replace broken denture teeth only.
Procedure 5610	Repair resin denture base.
Procedure 5620	Repair cast framework.
Procedure 5630	Repair or replace clasp.
Procedure 5640	Replace broken teeth – per tooth
Procedure 5650	Add tooth to partial denture to replace newly extracted natural tooth.
Procedure 5660	Add clasp to existing partial denture.
Procedure 5710	Rebase complete maxillary denture.
Procedure 5711	Rebase complete mandibular denture.
Procedure 5720	Rebase maxillary partial denture.
Procedure 5721	Rebase mandibular partial denture.
Procedure 5730	Reline complete maxillary denture – chairside.
Procedure 5731	Reline complete mandibular denture – chairside.
Procedure 5740	Reline partial maxillary denture – chairside.
Procedure 5741	Reline partial mandibular denture – chairside.
Procedure 5750	Reline complete maxillary denture – lab.
Procedure 5751	Reline complete mandibular denture – lab.
Procedure 5760	Reline partial maxillary denture – lab.
Procedure 5761	Reline partial mandibular denture – lab.
Procedure 5810	Interim complete denture (maxillary).

Procedure 5811 Interim complete denture (mandibular).

Procedure 5820 Interim partial denture (maxillary).

Procedure 5821 Interim partial denture (mandibular).

Procedure 5850 Tissue conditioning – maxillary.

Procedure 5851 Tissue conditioning – mandibular.

G. PROSTHETICS - FIXED

Procedure 6210 Pontic-cast with high noble metal.

Procedure 6240 Pontic-porcelain with high noble metal.

Procedure 6250 Pontic-resin with high noble metal.

Procedure 6750 Bridge crown-porcelain with high noble metal.

Procedure 6790 Bridge crown-full case with high noble metal.

Procedure 6930 Re-cement bridge.

Procedure 6940 Stress breaker.

Procedure 6970 Cast post and core in addition to bridge crown (endodontically treated tooth).

Procedure 6971 Cast post as part of bridge crown.

Procedure 6972 Prefabricated post and core in addition to bridge crown (endodontically treated tooth).

Procedure 6980 Repair fixed bridge.

Procedure 6999 Unspecified fixed prosthodontic procedure, by report.

H. ORAL SURGERY

1. EXTRACTIONS – GENERAL POLICIES

a. Diagnostic x-rays fully depicting subject tooth (teeth) are usually required for all intraoral surgical procedures. (See specific procedure code for details)

b. The extraction of asymptomatic teeth is not a benefit.

The following instances may be justified as being symptomatic:

i. Teeth which are involved with a cyst, tumor, or neoplasm.

ii. The extraction of all remaining teeth in preparation for a full prosthesis.

iii. A malaligned tooth that causes intermittent gingival inflammation.

iv. Perceptible radiologic pathology that fails to elicit symptoms.

c. By repot procedures may be used when the provider has encountered unforeseen complications which are not usually considered normal to the particular procedure listed.

Procedure 7110 Removal of erupted tooth, uncomplicated, first tooth

Procedure 7120	Removal of erupted tooth (teeth), uncomplicated, each additional tooth.
Procedure 7130	Removal of root or root tip.
Procedure 7210	Removal of erupted tooth, surgical.
Procedure 7220	Removal of impacted tooth – soft tissue: Removal of any permanent tooth by the open method which may or may not include removal of bone in those cases where the major portion of all of the crown of the tooth was covered by mucogingival tissue and not alveolar bone.
Procedure 7230	Removal of impacted tooth – partially bony.
Procedure 7240	Removal of impacted tooth – totally bony: Removal of any tooth by the open method where it is necessary to expose any portion of the crown of the tooth by removal of alveolar bone.
Procedure 7250	Surgical removal of residual tooth roots (cutting procedure).
Procedure 7285	Biopsy and pathology reports of oral tissue – hard: Refer to oral surgeon.
Procedure 7286	Biopsy and pathology reports of oral tissue – soft: Refer to oral surgeon.
Procedure 7310	Alveolectomy (Alveoloplasty): Is a collective term for the operation by which the shape and condition of the alveolar process is improved for preservation of the residual bone.
Procedure 7430	Excision of benign tumor – lesion diameter up to 1.25 cm.
Procedure 7431	Excision of benign tumor – lesion diameter greater than 1.25 cm.
Procedure 7440	Excision of malignant tumor – lesion diameter up to 1.25 cm.
Procedure 7441	Excision of malignant tumor – lesion diameter greater than 1.25 cm.
Procedure 7465	Destruction of lesion(s) by physical or chemical methods, by report.
Procedure 7510	Incision and drainage of abscess, intraoral soft tissue.
Procedure 7520	Incision and drainage of abscess, extraoral soft tissue.
Procedure 7550	Sequestrectomy for osteomyelitis or bone abscess, superficial.
Procedure 7970	Excision of hyperplastic tissue, per arch: A benefit when inflammatory hyperplastic tissue interferes with normal use of function of a prosthetic appliance.
Procedure 7971	Excision pericoronal gingiva, operculectomy.

I. ADJUNCTIVE GENERAL SERVICES

Must be pre-authorized. Claim must be accompanied by documentation from primary care physician as to the medical necessity.

1. General anesthesia as used for dental pain control means the elimination of all sensation accompanied by a state of unconsciousness.

2. Office (outpatient) general anesthesia may be payable when the provider indicates local anesthesia is contraindicated.

Procedure 9110	Emergency treatment, palliative, per visit.
Procedure 9220	General anesthesia – first thirty (30) minutes.

Procedure 9221	General anesthesia – each additional 15 minutes.
Procedure 9430	Office visit during regular office hours for treatment and/or observation of teeth and supporting structures.
Procedure 9440	Professional visit after regular office hours or to bedside.
Procedure 9930	Post-operative visit, complications (post surgical *e.g.*, osteitis).
Procedure 9940	Occlusal guard, by report.
Procedure 9951	Occlusal adjustment – limited.
Procedure 9952	Occlusal adjustment – complete.

J. UNLISTED PROCEDURES

Procedure 9999	Unlisted procedures; requires definition and requires prior authorization by County for non-emergency procedures..

VIII. NOT COVERED PROCEDURES

The following are not benefits under the program:

A. DIAGNOSTIC and PREVENTIVE

1. Preventive control program, including fissure sealant, prophylactic fillings, oral hygiene instruction, dietary instruction and prophylaxis when not in conjunction with restorative treatment. (Prophy's can be obtained at Sacramento City College Dental Hygiene Department).

B. ORAL SURGERY

1. Experimental procedures.
2. Asymptomatic extractions.
3. Surgical correction of the maxilla and mandible by grafts for denture retention.
4. Surgical treatment of temporomandibular joint disturbances.
5. Surgical treatment of prognathism or retrognathism.
6. Surgical treatment to correct congenital or developmental malformation.

C. PRESCRIBED DRUGS – Reimbursement for prescription drugs is not covered unless there is no other payor source and is limited to only those drugs that are currently prescribed by the dental community for dental related needs.

D. ORTHODONTIC SERVICES

E. RESTORATIVE DENTISTRY

1. Full mouth reconstruction procedure.
2. Cosmetic procedure and restorations (other than those for replacement of structure loss from caries) that are necessary to alter, restore or maintain occlusion. These include:
   a. Increasing vertical dimension.
   b. Replacing or stabilizing tooth structure loss by attrition.

c. Realignment of teeth.

d. Periodontal splinting.

e. Gnathologic recordings.

f. Equilibration.

g. Surgical treatment of disturbances of temporomandibular joint.

h. Services for the surgical treatment of prognathism or retrognathism.

3. Treatment of incipient or non-active caries as demonstrated radiographically.

F. PROSTHETICS

The program provides for replacement of missing teeth with full dentures or partials using standard procedures, when "medically necessary" by the dentist. A service is "medically necessary" or is a "medical necessity" when it is reasonable to protect life, to prevent significant illness or significant disability, or to alleviate sever pain.

Medically necessary dentures or partials must be preauthorized and are limited to once in a five (5) year period, unless rendered totally unfunctionable and not repairable.

Treatment involving the following is not covered:

- Specialized techniques
- Precious metal for removable appliances
- Overlays, implants and associated appliances
- Personalization or characterization

COUNTY OF SACRAMENTO **COST REIMBURSEMENT AGREEMENT NO. 7275-07/12-709 A4**

ATTACHMENT B AMENDMENT 4

Fee Schedule FY 2007-FY2012

CODE	DESCRIPTION	UOS	FEE
00110	Initial oral examination	0.4	$46.00
00120	Periodic oral examination	0.3	$34.50
00210	Intraoral-complete series (including bitewings)	0.7	$80.50
00220	Intraoral-periapical-first film	0.2	$23.00
00230	Intraoral-periapical-each additional film	0.1	$11.50
00240	Intraoral-occlusal film	0.3	$34.50
00270	Bitewing-single film	0.2	$23.00
00272	Bitewing-two films	0.3	$34.50
00274	Bitewing-four films	0.4	$46.00
00330	Panoramic film	0.6	$69.00
00470	Diagnostic casts	0.6	$69.00
01110	Prophylaxis-adult	0.6	$69.00
01120	Prophylaxis-child	0.5	$57.50
01201	Topical application of fluoride (including prophylaxis)-child	0.6	$69.00
01203	Topical application of fluoride (prophylaxis not included)-child	0.2	$23.00
01204	Topical application of fluoride (prophylaxis not included)-adult	0.3	$34.50
01205	Topical application of fluoride (including prophylaxis)-adult	0.7	$80.50
01351	Sealant-per tooth	0.3	$34.50
02110	Amalgam-one surface, primary	0.6	$69.00
02120	Amalgam-two surfaces, primary	0.7	$80.50
02130	Amalgam-three surfaces, primary	0.9	$103.50
02131	Amalgam-four or more surfaces, primary	1.0	$115.00
02140	Amalgam-one surface, permanent	0.7	$80.50
02150	Amalgam-two surfaces, permanent	0.9	$103.50
02160	Amalgam-three surfaces, permanent	1.0	$115.00
02161	Amalgam-four or more surfaces, permanent	1.2	$138.00
02330	Resin-one surface, anterior	0.9	$103.50
02331	Resin-two surfaces, anterior	1.0	$115.00
02332	Resin-three surfaces, anterior	1.2	$138.00
02335	Resin-four or more surfaces or involving incisal angle (anterior)	1.7	$195.50
02750	Crown-porcelain fused to high noble metal	7.8	$897.00
02751	Crown-porcelain fused to predominantly base metal	6.7	$770.50
02752	Crown-porcelain fused to noble metal	7.1	$816.50
02790	Crown-full cast high noble metal	7.0	$805.00
02791	Crown-full cast predominantly base metal	6.1	$701.50

05710	Rebase complete maxillary denture	3.4	$391.00
05711	Rebase complete mandibular denture	3.4	$391.00
05720	Rebase maxillary partial denture	3.4	$391.00
05721	Rebase mandibular partial denture	3.5	$402.50
05730	Reline complete maxillary denture (chairside)	1.7	$195.50
05731	Reline complete mandibular denture (chairside)	1.7	$195.50
05740	Reline maxillary partial denture (chairside)	1.7	$195.50
05741	Reline mandibular partial denture (chairside)	1.7	$195.50
05750	Reline complete maxillary denture (laboratory)	2.6	$299.00
05751	Reline complete mandibular denture (laboratory)	2.5	$287.50
05760	Reline maxillary partial denture (laboratory)	2.5	$287.50
05761	Reline mandibular partial denture (laboratory)	2.5	$287.50
05810	Interim complete denture (maxillary)	4.3	$494.50
05811	Interim complete denture (mandibular)	4.3	$494.50
05820	Interim partial denture (maxillary)	3.7	$425.50
05821	Interim partial denture (mandibular)	3.7	$425.50
05850	Tissue conditioning (maxillary)	1.0	$115.00
05851	Tissue conditioning (mandibular)	1.0	$115.00
06210	Pontic-cast high noble metal	7.0	$805.00
06211	Pontic-cast predominantly base metal	6.1	$701.50
06212	Ponic-cast noble metal	6.7	$770.50
06240	Pontic-porcelain fused to high noble metal	7.9	$908.50
06241	Pontic-porcelain fused to predominantly base metal	6.7	$770.50
06242	Pontic-porcelain fused to noble metal	7.0	$805.00
06750	Crown-porcelain fused to high noble metal	7.9	$908.50
06751	Crown-porcelain fused to predominantly base metal	6.6	$759.00
06752	Crown-porcelain fused to noble metal	7.0	$805.00
06790	Crown-full cast high noble metal	7.1	$816.50
06791	Crown-full cast predominantly base metal	6.3	$724.50
06792	Crown-full cast noble metal	7.0	$805.00
06930	Recement fixed partial denture	1.0	$115.00
06940	Stress breaker	2.6	$299.00
06970	Cast post and core in addition to fixed partial denture retainer	2.9	$333.50
06971	Cast post and core as part of a fixed partial denture retainer	2.9	$333.50
06972	Prefabricated post and core in addition to fixed partial denture retainer	2.3	$264.50
06973	Core build up for retainer, including any pins	1.8	$207.00
06980	Fixed partial denture repair, by report	5.5	$632.50
07110	Single tooth extraction	0.8	$92.00
07120	Each additional tooth extraction	0.8	$92.00
07130	Root removal-exposed roots	1.0	$115.00
07210	Surgical removal of erupted tooth requiring elevation of flap and/or removal of bone	1.3	$149.50
07220	Removal of impacted tooth-soft tissue	1.5	$172.50
07230	Removal of impacted tooth-partial bony	2.0	$230.00
07240	Removal of impacted tooth-complete bony	3.0	$345.00

07250	Surgical removal of residual tooth roots (cutting procedure)	1.4	$161.00
07285	Biopsy of oral tissue-hard	2.0	$230.00
07286	Biopsy of oral tissue-soft	1.5	$172.50
07310	Alveoloplasty in conjunction with extractions-per quadrant	1.3	$149.50
07311	Alveoloplasty not in conjunction with extractions-per quadrant	1.3	$149.50
07430	Excision of benign tumor-lesion diameter up to 1.25 cm	1.4	$161.00
07431	Excision of benign tumor-lesion diameter greater than 1.25 cm	2.0	$230.00
07440	Excision of malignant tumor-lesion diameter up to 1.25 cm	2.9	$333.50
07441	Excision of malignant tumor-lesion diameter greater than 1.25 cm	4.8	$552.00
07465	Destruction of lesion(s) by physical or chemical methods, by report	2.3	$264.50
07510	Incision and drainage of abscess-intraoral soft tissue	0.8	$92.00
07520	Incision and drainage of abscess-extraoral soft tissue	2.1	$241.50
07550	Sequestrectomy for osteomyelitis	2.9	$333.50
07970	Excision of hyperplastic tissue-per arch	2.3	$264.50
07971	Excision of pericoronal gingiva	0.9	$103.50
09110	Palliative (emergency) treatment of dental pain-minor procedure	0.7	$80.50
09430	Office visit for observation (during office hours, no other service performed)	0.4	$46.00
09440	Office visit after regularly scheduled hours	1.0	$115.00
09930	Treatment of complication (post surgical) unusual circumstances, by report	0.4	$46.00
09940	Occlusal guard, by report	3.8	$437.00
09951	Occlusal adjustment-limited	1.0	$115.00
09952	Occlusal adjustment-complete	3.8	$437.00
09999	Unspecified adjunctive procedure, by report		$0.00

COUNTY OF SACRAMENTO **COST REIMBURSEMENT AGREEMENT NO. 7275-07/08-709**

AGREEMENT

THIS AGREEMENT is made and entered into as of this 1st day of March, 2007, by and between the COUNTY OF SACRAMENTO, a political subdivision of the State of California, hereinafter referred to as "COUNTY", and EL DORADO COUNTY PUBLIC HEALTH DEPARTMENT, a political subdivision of the State of California, hereinafter referred to as "CONTRACTOR".

RECITALS

WHEREAS, Title I of the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act planning process supports direct services for people living with HIV disease (PLWHs) and creates a comprehensive, participatory planning process designed to ensure that local health care and social service programs are responsive to individuals living with HIV disease; and

WHEREAS, the designated grantee for the Title I Ryan White CARE Program for the Sacramento County Eligible Metropolitan Area (EMA) is the COUNTY; and

WHEREAS, COUNTY desires to extend certain services to the residents of the County of El Dorado by contracting with CONTRACTOR; and CONTRACTOR is equipped, staffed and prepared to provide such services on the terms and conditions set forth in this Agreement; and

WHEREAS, the Director of the Department of Health and Human Services is authorized to enter into AGREEMENT pursuant to Sacramento County Resolution No. 2005-0824, approved June 21, 2005;

WHEREAS, COUNTY AND CONTRACTOR desire to enter into this Agreement on the terms and conditions set forth herein.

NOW, THEREFORE, in consideration of the mutual promises hereinafter set forth, COUNTY and CONTRACTOR agree as follows:

I. SCOPE OF SERVICES

CONTRACTOR shall provide services in the amount, type and manner described in Exhibit A, which is attached hereto and incorporated herein.

II. TERM

This Agreement shall be effective and commence as of the date first written above and shall end on February 29, 2008.

III. NOTICE

Any notice, demand, request, consent, or approval that either party hereto may or is required to give the other pursuant to this Agreement shall be in writing and shall be either personally delivered or sent by mail, addressed as follows:

TO COUNTY	TO CONTRACTOR
DIRECTOR Department of Health & Human Services 7001-A East Parkway, Suite 1000 Sacramento, CA 95823	El Dorado County Public Health Department 929 Spring Street Placerville, CA 95667

Either party may change the address to which subsequent notice and/or other communications can be sent by giving written notice designating a change of address to the other party, which shall be effective upon receipt.

IV. COMPLIANCE WITH LAWS

CONTRACTOR shall observe and comply with all applicable Federal, State, and County laws, regulations and ordinances.

E. It is further understood and agreed that CONTRACTOR must issue W-2 and 941 Forms for income and employment tax purposes, for all of CONTRACTOR's assigned personnel under the terms and conditions of this Agreement.

X. CONTRACTOR IDENTIFICATION

CONTRACTOR shall provide the COUNTY with the following information for the purpose of compliance with California Unemployment Insurance Code Section 1088.8 and Sacramento County Code Chapter 2.160: CONTRACTOR's name, address, telephone number, social security number and whether dependent health insurance coverage is available to CONTRACTOR.

XI. COMPLIANCE WITH CHILD, FAMILY AND SPOUSAL SUPPORT REPORTING OBLIGATIONS

A. CONTRACTOR's failure to comply with state and federal child, family and spousal support reporting requirements regarding a CONTRACTOR's employees or failure to implement lawfully served wage and earnings assignment orders or notices of assignment relating to child, family and spousal support obligations shall constitute a default under this Agreement.

B. CONTRACTOR's failure to cure such default within 90 days of notice by COUNTY shall be grounds for termination of this Agreement.

XII. BENEFITS WAIVER

If CONTRACTOR is unincorporated, CONTRACTOR acknowledges and agrees that CONTRACTOR is not entitled to receive the following benefits and/or compensation from COUNTY: medical, dental, vision and retirement benefits, life and disability insurance, sick leave, bereavement leave, jury duty leave, parental leave, or any other similar benefits or compensation otherwise provided to permanent civil service employees pursuant to the County Charter, the County Code, the Civil Service Rule, the Sacramento County Employees' Retirement System and/or any and all memoranda of understanding between COUNTY and its employee organizations. Should CONTRACTOR or any employee or agent of CONTRACTOR seek to obtain such benefits from COUNTY, CONTRACTOR agrees to indemnify and hold harmless COUNTY from any and all claims that may be made against COUNTY for such benefits.

XIII. CONFLICT OF INTEREST

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

XIV. USE OF FUNDS

It is understood and agreed that no funds provided by COUNTY pursuant to this Agreement shall be used by CONTRACTOR for any political activity or political contribution.

XV. NONDISCRIMINATION IN EMPLOYMENT, SERVICES, BENEFITS AND FACILITIES

A. CONTRACTOR agrees and assures COUNTY that CONTRACTOR and any subcontractors shall comply with all applicable federal, state, and local anti-discrimination laws, regulations, and ordinances and to not unlawfully discriminate, harass, or allow harassment against any employee, applicant for employment, employee or agent of COUNTY, or recipient of services contemplated to be provided or provided under this Agreement, because of race, ancestry, marital status, color, religious creed, political belief, national origin, ethnic group identification, sex, sexual orientation, age (over 40), medical condition (including HIV and AIDS), or physical or mental disability. CONTRACTOR shall ensure that the evaluation and treatment of its employees and applicants for employment, the treatment of COUNTY employees and agents, and recipients of services are free from such discrimination and harassment.

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

C. CONTRACTOR agrees to compile data, maintain records and submit reports to permit effective enforcement of all applicable antidiscrimination laws and this provision.

XXI. LEGAL TRAINING INFORMATION

If under this Agreement CONTRACTOR is to provide training of County personnel on legal issues, then CONTRACTOR shall submit all training and program material for prior review and written approval by County Counsel. Only those materials approved by County Counsel shall be utilized.

XXII. SUBCONTRACTS, ASSIGNMENT

A. CONTRACTOR shall obtain prior written approval from COUNTY before subcontracting any of the services delivered under this Agreement. CONTRACTOR remains legally responsible for the performance of all contract terms including work performed by third parties under subcontracts. Any subcontracting will be subject to all applicable provisions of this Agreement. CONTRACTOR shall be held responsible by COUNTY for the performance of any subcontractor whether approved by COUNTY or not.

B. This Agreement is not assignable by CONTRACTOR in whole or in part, without the prior written consent of COUNTY.

XXIII. AMENDMENT AND WAIVER

Except as provided herein, no alteration, amendment, variation, or waiver of the terms of this Agreement shall be valid unless made in writing and signed by both parties. Waiver by either party of any default, breach or condition precedent shall not be construed as a waiver of any other default, breach or condition precedent, or any other right hereunder. No interpretation of any provision of this Agreement shall be binding upon COUNTY unless agreed in writing by DIRECTOR and counsel for COUNTY.

XXIV. SUCCESSORS

This Agreement shall bind the successors of COUNTY and CONTRACTOR in the same manner as if they were expressly named.

XXV. TIME

Time is of the essence of this Agreement.

XXVI. INTERPRETATION

This Agreement shall be deemed to have been prepared equally by both of the parties, and the Agreement and its individual provisions shall not be construed or interpreted more favorably for one party on the basis that the other party prepared it.

XXVII. DIRECTOR

As used in this Agreement, "DIRECTOR" shall mean the Director of the Department of Health and Human Services, or his/her designee.

XXVIII. DISPUTES

In the event of any dispute arising out of or relating to this Agreement, the parties shall attempt, in good faith, to promptly resolve the dispute mutually between themselves. If the dispute cannot be resolved by mutual agreement, nothing herein shall preclude either party's right to pursue remedy or relief by civil litigation, pursuant to the laws of the State of California.

XXIX. TERMINATION

A. Either party may terminate this Agreement without cause upon thirty (30) days written notice to the other party. Notice shall be deemed served on the date of mailing. If notice of termination for cause is given by COUNTY to CONTRACTOR and it is later determined that CONTRACTOR was not in default or the default was excusable, then the notice of termination shall be deemed to have been given without cause pursuant to this paragraph (A).

B. COUNTY may terminate this Agreement for cause immediately upon giving written notice to CONTRACTOR should CONTRACTOR materially fail to perform any of the covenants contained in this Agreement in the time and/or manner specified. In the event of such termination, COUNTY may proceed with the work in any manner deemed proper by

1. CONTRACTOR shall adhe... to the requirements contained in Title 42, Code of Federal Regulations (CFR) Part 54;

2. CONTRACTOR's services shall be provided in a manner consistent with the Establishment Clause and the Free Exercise Clause of the First Amendment of the United States Constitution (42 CFR Part 54.3);

3. If CONTRACTOR offers inherently religious activities, they shall be provided separately, in time or location, from the programs or services for which the organization receives funds from Federal, State or local government sources. Participation in religious activities must be voluntary for program beneficiaries (42 CFR Part 54.4);

4. CONTRACTOR shall not expend any Federal, State or local government funds to support any inherently religious activities such as worship, religious instruction, or proselytization (42 CFR Part 54.5);

5. CONTRACTOR shall not, in providing program services or engaging in outreach activities under applicable programs, discriminate against a program beneficiary or prospective program beneficiary on the basis of religion, a religious belief, a refusal to hold a religious belief, or a refusal to actively participate in a religious practice (42CFR Part 54.7);

6. CONTRACTOR shall inform program beneficiaries that they may refuse to participate in any religious activities offered by CONTRACTOR;

7. CONTRACTOR shall inform program beneficiaries that, if they object to the religious character of the program, they have the right to a referral to an alternate service provider to which they have no objections (42 CFR Part 54.8); and,

8. CONTRACTOR shall, within a reasonable time of learning of a beneficiary's objection to the religious character of the program, refer the program beneficiary to an alternate service provider (42 CFR Part 54.8).

If 42 U.S.C. 2000e-1 regarding employment practices is applicable to this Agreement, it shall supersede 42 CFR Part 54.7 to the extent that 42 CFR Part 54.7 conflicts with 42 U.S.C. 2000e-1.

XXXVI. ADDITIONAL PROVISIONS

The additional provisions contained in Exhibits A, B, C, D, E, F, G and Attachments A and B attached hereto are part of this Agreement and are incorporated herein by reference.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be duly executed as of the day and year first written above.

COUNTY OF SACRAMENTO, a political subdivision of the State of California

By _____
Lynn Frank, Director, Department of Health and Human Services. Approval delegated pursuant to Sacramento County Code Section 2.61.012 (h)

Date: 7/23/07

EL DORADO COUNTY PUBLIC HEALTH DEPARTMENT

By _____
Gayle Erbe-Haughin, Director for Public Health

Date: 6/29/07

EXHIBIT A to Agreement
between the COUNTY OF SACRAMENTO
hereinafter referred to as "COUNTY", and
EL DORADO COUNTY PUBLIC HEALTH DEPARTMENT,
hereinafter referred to as "CONTRACTOR"

SPECIAL PROVISIONS

The Special Provisions listed below will apply to Exhibits A-1 through A-6 of this Agreement.

I. SERVICE LOCATION(S)

Facility Name(s):	El Dorado County Public Health Department
Street Address:	3053 Harrison Ave., Su. 203
City and Zip Code:	South Lake Tahoe, CA 96151

Facility Name(s):	El Dorado County Public Health Department
Street Address:	550 Pleasant Valley Road, Su. 2E
City and Zip Code:	Diamond Springs, CA 95619

II. COUNTY SERVICE PERFORMANCE MONITOR

Name and Title:	Health Program Coordinator (Adrienne Rogers)
Organization:	Department of Health and Human Services, Public Health/Ryan White CARE Program
Street Address:	7001-A East Parkway, Suite 600
City and Zip Codes:	Sacramento, CA 95823

III. CONTRACTOR CONTRACT ADMINISTRATOR

The El Dorado County officer or employee responsible for administering this agreement is:

Name and Title:	Michael Ungeheuer, Deputy Director
Organization:	El Dorado County Public Health Department
Street Address:	931 Spring Street, Suite 3
City and Zip Codes:	Placerville, CA 95667

IV. COUNTY RESIDENCY

Funding provided under Exhibit A of this Agreement is for services to Sacramento, El Dorado and Placer County residents only. A person is a Sacramento, El Dorado or Placer County resident if he/she is currently staying in one of these counties with the intent to remain and live in one of the specified counties. Any person who comes to Sacramento, El Dorado or Placer County for the express purpose of qualifying to receive services from a COUNTY-funded program, and intends to leave the county after receipt of services, is not considered a resident. Proof of residency can be established by the following:

A. Any bill or correspondence current to within the previous two weeks showing the individual's name and a Sacramento, El Dorado or Placer County address

B. Written statement by homeless shelter staff verifying that the individual has been in shelter residence in Sacramento, El Dorado or Placer County continuously for the previous two weeks

C. Current state issued identification card reflecting a Sacramento, El Dorado or Placer County address

D. Other reliable evidence that establishes Sacramento, El Dorado or Placer County residency

D. CONTRACTOR shall use best efforts to achieve the outcomes described in sections 2 to 7 below and provide the levels of service delivery as follows:

1. Number of Unduplicated Clients: A minimum of 8 clients will receive Ambulatory/Outpatient Medical Services during the project year.

   a) Number of Units of Service: A minimum of 1 unit of service per client and an overall maximum of 2,181.82 units of service will be provided (1 unit of service = One vendor paid dollar for primary care visit with Health Care Provider).

   b) Number of Units of Service: A minimum of 1 unit of service per client and an overall maximum of 454.55 units of service will be provided (1 unit of service = 1 vendor paid dollar for lab visit).

   c) Number of Units of Service: A minimum of 1 unit of service per client and an overall maximum of 454.55 units of service will be provided (1 unit of service – 1 vendor paid dollar for specialty care visit with Health Care Provider).

2. Documentation of on-going medical care will be charted in case files for 100% of clients.

3. The number of Hospital admissions as a ratio of the annual unduplicated caseload will be tracked and trended.

4. The number of emergency room visits as a ratio of the annual unduplicated caseload will be tracked and trended.

5. CD4 Counts and Viral Load counts as a ratio of the annual unduplicated caseload will be tracked and trended.

6. Death Rates per year as a percentage of annual unduplicated clients will be tracked and trended.

7. 70% of clients will receive a minimum of one primary care visit per year (12 month period).

8. CONTRACTOR shall document and track all service provision to clients through the SEMAS web-based database to identify clients who may withdraw from care.

9. CONTRACTOR will provide screening and treatment to 95% of clients reporting opportunistic infections who remain in care.

10. 60% of clients on HAART therapy will show improved or stable CD4 and viral load counts.

11. 100% of primary care services offered will meet Public Health Standard guidelines.

4. Information and Referral: CONTRACTOR shall make referrals to the most appropriate resource to meet needs prioritized in the client's Case Plan. CONTRACTOR will document referrals and provide follow-up action to ensure that services are provided.

5. Case Files: CONTRACTOR shall maintain an individualized case file for each client which contains documentation of all services provided, appropriate signed release of information forms and case notes documenting client contact and resource and referral follow-up.

C. CONTRACTOR shall use best efforts to achieve the outcomes described in sections 3, 4, 5, 6, 7 and 8 below and provide the level of service delivery as follows:

1. Number of Unduplicated Clients: A minimum of 1 and a maximum of 28 clients will receive case management services during the project year

2. Number of Units of Service: A minimum of 8 units of service per client and an overall maximum of 2,702.56 units of service will be provided not to exceed the total contract award (1 unit of service = 15 minutes of field based face-to-face encounter or 15 minutes of field based other encounter).

3. 100% of participants will have had an assessment of medical and psychosocial needs, which determined appropriate resource referrals.

4. 100% of program participants will have a Plan of Care prioritizing needs and identifying goals to meet those needs.

5. 70% of unduplicated clients will maintain/achieve their individual care plan objectives as measured over twelve months.

6. Documentation of assistance provided will be charted in case files for 100% of clients.

7. 100% of participants will be reassessed at least once during the project year.

8. Documentation of on-going medical care will be charted in case files for 100% of clients.

9. CONTRACTOR will document and track all service provision to clients through the SEMAS web-based database in order to identify clients who may withdraw from care.

10. 100% of clients who do not have an identified primary care provider at intake will receive a referral to an appropriate physician or clinic.

11. 70% of clients receiving case management will maintain routine medical care (minimum one primary care visit per year that includes a CD4 count, viral load test or on ART).

3. Include client involvement.

F. CONTRACTOR shall provide referral and linkages to other county and community based services when clinically appropriate.

G. CONTRACTOR shall ensure interagency coordination, communication, and/or collaboration of services with other agencies with which the referred client is involved as evidenced by client chart documentation and internal utilization review.

H. CONTRACTOR shall provide appropriate referral and linkage for clients who do not meet criteria, are transitioning out of services, or require services beyond the scope of the contracted program.

I. CONTRACTOR shall demonstrate program effectiveness through performance outcomes.

J. CONTRACTOR shall provide culturally competent services by:

1. Seeking staff that provides multi-cultural representation on all levels.

2. Providing services to referred clients in a manner that is sensitive and responsive to racial, ethnic, linguistic, and cultural differences as evidenced by client chart documentation and internal utilization review.

K. CONTRACTOR shall provide services at hours that are convenient and acceptable to the referred client.

III. SERVICE DELIVERY REQUIREMENTS

A. Service Eligibility: CONTRACTOR shall perform an intake process on each participant seeking Ryan White-funded mental health services. The intake process will include determining eligibility for Ryan White-funded services, completing the Ryan White Intake Form, and providing the participant with an orientation to CONTRACTOR's program. The Intake process should be conducted within a maximum of 30 days of initial client contact, unless the agency can no longer accept clients as a result of a lack of funding or available staff. Client's placed on a waiting list must be provided with referrals to alternate available Ryan White Case Management agencies, and all waiting lists must be reported to the Ryan White Fiscal Agent. Once funding or staff become available, clients placed on the waiting list should be seen in order of need.

B. Service Eligibility for Non-Infected Clients: Non-infected individuals may be appropriate candidates for CARE Act services in limited situations, but these services must always have at least indirect benefit to a person with HIV. The Sacramento EMA's adopted Mental health Service Standards outline these limited circumstances.

C. Evaluation and Assessment: During the initial intake process, CONTRACTOR shall perform an assessment of medical and psychosocial needs of the participant using the adopted EMA Case Management Service Standards as a guide to determine appropriate service and/or resource referrals.

D. CONTRACTOR shall document assessments, client plans, and progress notes, which accurately represent the mental health service provided and client progress.

E. CONTRACTOR shall meet all Ryan White program-staffing requirements. Staff clinicians who provide the services must meet all licensure and certification requirements as established by the State of California, Board of Behavioral Sciences. Registered interns may provide services if they have appropriate supervision by mental health professionals licensed within the State of California to provide mental health services and are employed directly by the applicant organization. It is understood that clinicians knowledgeable of HIV+ client needs will provide mental health services.

F. CONTRACTOR will document and track all service provision to clients through the SEMAS web-based database in order to identify clients who may withdraw from care.

G. CONTRACTOR shall use best efforts to achieve the outcomes described in sections 3, 4, 5, 6, 7 and 8 below and provide the level of service delivery as follows:

1. Number of Unduplicated Clients: A minimum of 1 adult will receive individual psychological counseling services.

EXHIBIT A-4 to Agreement
between the COUNTY OF SACRAMENTO,
hereinafter referred to as "COUNTY", and
EL DORADO COUNTY PUBLIC HEALTH DEPARTMENT,
hereinafter referred to as "CONTRACTOR"

SCOPE OF SERVICES: SUPPORT SERVICE-TRANSPORTATION

I. PROJECT DESCRIPTION

A. **Type of Service:** CONTRACTOR will provide Support Services in the form of Transportation to Persons Living with HIV/AIDS (PLWH/A). Many PLWH/A have multiple needs because of the numerous logistical barriers to accessing care and/or staying in care, including, but not limited to: poverty, isolation, trust of government systems, homelessness, mental health (including multiple diagnoses), ability to pay for medical services, and discrimination. Support Services – Transportation shall provide assistance to promote quality of life and remove major barriers that prevent PLWH/A from accessing needed primary medical care.

B. **Population:** Persons living with HIV/AIDS in the Sacramento Eligible Metropolitan Area (EMA), which encompasses El Dorado, Placer, and Sacramento Counties, with a primary focus on those persons who receive and/or enter and remain in primary medical care for their HIV/AIDS related condition(s).

C. **Goal:** Desired outcome is to provide basic Support Services - Transportation to persons living with HIV/AIDS in the Sacramento EMA and to improve their ability to enter into and/or remain in primary medical care.

II. SERVICES

A. CONTRACTOR will maintain and enhance individual health care by providing Support Services to PLWH/A in the Sacramento EMA. CONTRACTOR shall establish and implement policies and procedures that ensure the referred client receives timely, effective, and quality Support Services - Transportation that meet their individual needs as determined by a Plan of Care developed by a Sacramento EMA case management agency that is Ryan White CARE Program funded. Exceptions: clients receiving volunteer-based Transportation Services, Buddy/Companion Services, Peer/Support Groups and/or Service Outreach/Case Funding, do not require case management participation.

B. CONTRACTOR shall ensure Support Services – Transportation are designed as coordinated services to facilitate access to primary medical care and to promote continuity of care. It is the intent of these services to improve the quality of life of persons living with HIV/AIDS in the Sacramento EMA.

C. CONTRACTOR shall perform an intake process for each client meeting eligibility criteria for Transportation Support Services. The intake process will include determining eligibility for Ryan White-funded services, completing the Ryan White Intake Form, and providing the participant with an orientation to the Support Services CONTRACTOR provides. The Intake process should be conducted within a maximum of 30 days of initial client contact, unless the agency can no longer accept clients as a result of a lack of funding or available staff. Client's placed on a waiting list must be provided with referrals to alternate available Ryan White Case Management agencies, and all waiting lists must be reported to the Ryan White Fiscal Agent. Once funding or staff become available, clients placed on the waiting list should be seen in order of need.

D. CONTRACTOR shall make referrals to the most appropriate resources to meet the needs prioritized in the client's Plan of Care, will document referrals and provide follow-up action to ensure that referred services were/are provided.

E. CONTRACTOR shall provide a minimum level of service delivery as follows:

1. **SS-Transportation:** Conveyance services provided to a client in order to access medical care or HIV-related psychosocial services and transportation to basic local, state, and federal entitlement program facility sites within the EMA only. Conveyance may be provided through joint-agency arrangement for volunteer-based transportation services, routinely or on an emergency basis via bus passes, or as a last resort, and clearly documented as an immediate need, taxicab services through an appropriate vendor.

2. Unduplicated Clients: A minimum of 23 clients will receive transportation assistance during the contract year.

COUNTY OF SACRAMENTO **COST REIMBURSEMENT AGREEMENT NO. 7275-07/08-709**

EXHIBIT A-5 to Agreement
between the COUNTY OF SACRAMENTO,
hereinafter referred to as "COUNTY", and
EL DORADO COUNTY PUBLIC HEALTH DEPARTMENT,
hereinafter referred to as "CONTRACTOR"

SCOPE OF SERVICES: ORAL HEALTH CARE

I. PROJECT DESCRIPTION

A. **Type of Program:** CONTRACTOR will provide Oral Health Care to People Living with HIV/AIDS (PLWH). Under the Oral Health Care Program the CONTRACTOR will provide the following services: diagnostic, prophylactic and therapeutic services rendered by licensed dentists, dental hygienists, dental assistants and other appropriately licensed or certified professional practitioners.

B. **Length of Treatment:** Length of treatment will be determined based on the diagnostic assessment by a licensed dentist of emergency Oral Health Care required and authorized under the current adopted Ryan White CARE Program Covered Dental Procedures attached as Attachment A.

C. **Population:** HIV infected persons in the Sacramento EMA with a primary focus on persons who need improvement in dental health.

II. SERVICES

A. CONTRACTOR will maintain and enhance individual health care by providing Oral Health Care to People Living with HIV/AIDS in the Sacramento EMA.

1. CONTRACTOR shall establish and implement policies and procedures that ensure that referred clients receive timely, effective, and quality Oral Health Care that meets his/her special needs.

2. CONTRACTOR shall establish and implement policies and procedures that incorporate and ensure compliance of ethical standards as established for all health care providers and legal standards as defined by federal and state governments regulating confidentiality (Civil Codes 38.1, 38.2, 38.3, Evidence Code 1012).

3. CONTRACTOR will provide access to Oral Health Care for People Living with HIV/AIDS in the Sacramento EMA. Oral Health Care will be limited to the services listed in the Ryan White CARE Program Covered Dental Procedures Units of Services (UOS) Schedule 2007/2008 attached as Attachment B.

4. CONTRACTOR shall perform an intake process on each client meeting eligibility criteria for Oral Health Care services. The intake process will include determining eligibility for Ryan White-funded services, completing the Ryan White Intake Form, and providing the participant with an orientation to the CONTRACTOR'S SERVICE PROGRAM. The Intake process should be conducted within a maximum of 30 days of initial client contact, unless the agency can no longer accept clients as a result of a lack of funding or available staff. Client's placed on a waiting list must be provided with referrals to alternate available Ryan White Case Management agencies, and all waiting lists must be reported to the Ryan White Fiscal Agent. Once funding or staff become available, clients placed on the waiting list should be seen in order of need.

5. Documentation of on-going dental care will be charted in case files for 100% of clients.

6. CONTRACTOR shall document and track all service provision to clients through the SEMAS web-based database to identify clients who may withdraw from care.

7. CONTRACTOR shall use best efforts to achieve the outcomes described in sections a. through d. below:

COUNTY OF SACRAMENTO **COST REIMBURSEMENT AGREEMENT NO. 7275-07/08-709**

EXHIBIT A-6 to Agreement
between the COUNTY OF SACRAMENTO,
hereinafter referred to as "COUNTY", and
EL DORADO COUNTY PUBLIC HEALTH DEPARTMENT,
hereinafter referred to as "CONTRACTOR"

SCOPE OF SERVICES: EMERGENCY FINANCIAL ASSISTANCE

I. PROJECT DESCRIPTION

A. **Type of Service:** CONTRACTOR will provide Emergency Financial Assistance to Persons Living with HIV/AIDS (PLWH/A). Many PLWH/A have multiple needs because of the numerous logistical barriers to accessing care and/or staying in care, including, but not limited to: poverty, isolation, trust of government systems, homelessness, mental health (including multiple diagnoses), ability to pay for medical services, and discrimination. Support Services shall provide assistance to promote quality of life and remove major barriers that prevent PLWH/A from accessing needed primary medical care..

B. **Population:** Persons living with HIV/AIDS in the Sacramento Eligible Metropolitan Area (EMA), which encompasses El Dorado, Placer, and Sacramento Counties, with a primary focus on those persons who receive and/or enter and remain in primary medical care for their HIV/AIDS related condition(s).

C. **Goal:** Desired outcome is to provide basic Emergency Financial Assistance to persons living with HIV/AIDS in the Sacramento EMA and to improve their ability to enter into and/or remain in primary medical care.

II. SERVICES

A. CONTRACTOR will maintain and enhance individual health care by providing Emergency Financial Assistance to PLWH/A in the Sacramento EMA. CONTRACTOR shall establish and implement policies and procedures that ensure the referred client receives timely and effective Emergency Financial Assistance that meets their individual needs as determined by a Plan of Care developed by a Sacramento EMA case management agency that is Ryan White CARE Program funded.

B. CONTRACTOR shall ensure Emergency Financial Assistance is designed as a coordinated service to facilitate access to primary medical care and to promote continuity of care. It is the intent of these services to improve the quality of life of persons living with HIV/AIDS in the Sacramento EMA.

C. CONTRACTOR shall perform an intake process for each client meeting eligibility criteria for Emergency Financial Assistance. The intake process will include determining eligibility for Ryan White-funded services, completing the Ryan White Intake Form, and providing the participant with an orientation to the Emergency Financial Assistance CONTRACTOR provides. The Intake process should be conducted within a maximum of 30 days of initial client contact, unless the agency can no longer accept clients as a result of a lack of funding or available staff. Clients placed on a waiting list must be provided with referrals to alternate available Ryan White Case Management agencies, and all waiting lists must be reported to the Ryan White Fiscal Agent. Once funding or staff becomes available, clients placed on the waiting list should be seen in order of need.

D. CONTRACTOR shall make referrals to the most appropriate resources to meet the needs prioritized in the client's Plan of Care, will document referrals and provide follow-up action to ensure that referred services were/are provided.

E. CONTRACTOR shall provide a minimum level of service delivery as follows:

1. **Other Critical Needs:** Services developed to meet the needs of clients not listed in other support service categories, such as short-term direct emergency financial assistance for health insurance premiums and other critical needs. Payment on behalf of client shall be made to the provider of said assistance or need directly. Ryan White CARE Program-funded clients shall not receive any direct financial assistance payments.

COUNTY OF SACRAMENTO **COST REIMBURSEMENT AGREEMENT NO. 7275-07/08-709**

EXHIBIT B to Agreement
between the COUNTY OF SACRAMENTO,
hereinafter referred to as "COUNTY",
and EL DORADO COUNTY PUBLIC HEALTH DEPARTMENT,
hereinafter referred to as "CONTRACTOR"

INSURANCE REQUIREMENTS FOR CONTRACTORS

Each party, at its sole cost and expense, shall carry insurance, or self-insure its activities in connection with this Agreement, and obtain, keep in force and maintain, insurance or equivalent program of self-insurance, for professional liability, general liability, workers compensation and business automobile liability adequate to cover its potential liabilities hereunder.

Exhibit C-1 to Agreement
Between the COUNTY OF SACRAMENTO,
herein referred to as "COUNTY", and
EL DORADO COUNTY PUBLIC HEALTH DEPARTMENT
hereinafter referred to as "CONTRACTOR"
Service Category: Direct Services

RYAN WHITE SERVICES BUDGET NARRATIVE

Line Item	Amount
PERSONNEL	
ADMINISTRATIVE SERVICES OFFICER - (Raines): 10% of FTE @ $52,853 per year. Reviews and reconciles subcontractor claims for Ryan White Services for submission to Fiscal Agent.	$5,285.00
FRINGE BENEFITS: Includes insurance benefits, retirement, workman's compensation, parking or bus pass reimbursement, payroll taxes, etc. (30%)	$1,586.00
TOTAL PERSONNEL EXPENSES	**$6,871.00**
OPERATING EXPENSES	
SUBCONTRACT: Subcontract with Sierra Foothills AIDS Foundation to provide Case Management inlcuding intake/assessment, ambulatory care, food vouchers and nutritional supplements; mental health, transportation, dental services, prescription medications, alternative/complementary therapy services; housing assistance and other critical need financial assistance.	$46,597.00
TOTAL OPERATING EXPENSES	**$46,597.00**
TOTAL DIRECT EXPENSES	**$53,468.00**
INDIRECT COSTS: Includes but is not limited to, program oversight and administrative support services including, accounting services, maintenance of personnel files and procedures, and legal services associated with personnel and other operations; insurance, payroll services, pension plan administration, other benefits administration, audit and expenses, operating expenses associated with the administrative services. Calculated at 10% of direct costs.	$0.00
TOTAL ANNUAL BUDGET	**$53,468.00**

1. All applications and . rds concerning an individual made or kept b, ONTRACTOR, COUNTY, or any public officer or agency in connection with the Welfare and Institutions Code relating to any form of public social services or health services provided under this Agreement shall be confidential and shall not be open to examination for any purpose not directly connected with the administration of such public social or health services.

2. No person will publish or disclose, or use or cause to be published, disclosed, or used, any confidential information pertaining to an applicant or recipient of services. Applicant and recipient records and information shall not be disclosed by CONTRACTOR to third parties without COUNTY'S consent or the consent of the applicant/recipient.

B. CONTRACTOR agrees to inform all of his/her employees, agents, subcontractors and partners of the above provision and that knowing and intentional violation of the provisions of said State law is a misdemeanor.

VI. QUALITY ASSURANCE AND PROGRAM REVIEW

A. CONTRACTOR shall permit, at any reasonable time, personnel designated by DIRECTOR to come on CONTRACTOR's premises for the purpose of making periodic inspections to evaluate the effectiveness of the services rendered pursuant to this Agreement. At reasonable times during normal business hours, COUNTY or DIRECTOR and/or their appropriate audit agency or designee shall have the right to inspect or otherwise evaluate the cost, quality, appropriateness and timeliness of services performed and to audit and inspect any books and records of CONTRACTOR which pertain to services performed and determination of amount payable under this Agreement. CONTRACTOR shall furnish DIRECTOR with such information as may be required to evaluate fiscal and program effectiveness of the services being rendered.

B. CONTRACTOR shall also use evaluation questionnaires or other tools supplied by the COUNTY for the purpose of evaluation of client satisfaction of services provided.

C. CONTRACTOR shall integrate service directives and/or service standards adopted by the HIV Health Services Planning Council into existing program models. If applicable, these directives and/or service standards will be furnished to the CONTRACTOR along with this Agreement. The CONTRACTOR may request an exemption from certain provisions of the Council service directives and/or standards. The COUNTY, as Fiscal Agent of the Sacramento Region EMA, retains discretionary authority to approve or deny requests for any exemption. All exemption requests, with narrative justification, must be submitted in writing in advance of anticipated need.

VII. RECORDS

A. Client Records:

1. CONTRACTOR shall maintain adequate client records on each individual client that includes diagnostic studies (when applicable), records of client interviews, progress notes, and records of services provided by the various professional and paraprofessional personnel in sufficient detail to permit an evaluation of services. Such records shall comply with all applicable Federal, State and COUNTY record maintenance requirements.

2. CONTRACTOR will maintain a completed Ryan White Intake Form for all non-anonymous clients in each client case file.

3. CONTRACTOR will track and report needs of clients, including documentation of any needs that are not provided for by funding under Title I/II of the Ryan White CARE Act.

4. CONTRACTOR shall maintain documentation in client case files that funds are not utilized to make payments for any item or service to the extent that payment has been made, with respect to that item or service by any other source of funds. Ryan White Title I and Title II-funded services are considered "Payer of Last Resort".

B. Financial Records:

CONTRACTOR shall maintain complete financial records that clearly reflect the actual cost of and related fees and reimbursements received for each type of service for which payment is claimed. The client eligibility determination and the fees charged to, and collected from clients shall also be reflected therein. Any apportionment of costs shall be made in accordance with generally accepted accounting principles.

contract period, the i ›endent Audit/Review shall cover the entire iod of the Agreement for which services were provided.

4. CONTRACTOR must submit to Sacramento County Department of Health and Human Services three (3) copies of the Audit/Review, as described in OMB Circular A-133, within the earlier of 30 days after receipt of the auditor's report(s) or no later than six months following the end of the contract year or termination of the Agreement. Should there be any delay anticipated, CONTRACTOR shall immediately inform DIRECTOR of the delay. The Audit/Review shall be sent to the following address:

Sacramento County DHHS, Fiscal Services
7001-A East Parkway, Suite 1100
Sacramento, CA 95823

B. Pursuant to OMB circular A-133 if CONTRACTOR expends less than $500,000 per year in total Federal funds from all sources (excluding Drug/Medi-Cal), COUNTY shall monitor on an annual basis the CONTRACTOR's activities to ensure that such funds are used for authorized purposes in compliance with laws, regulations, and the provisions of this Agreement and that performance goals are achieved. In addition, COUNTY shall utilize Reviews provided by CONTRACTOR to meet monitoring objectives. Such reviews shall include, but are not limited to; copies of invoices, canceled checks, and time sheets.

C. Pursuant to OMB Circular A-133, if CONTRACTOR expends $500,000 or more per year in Federal funds from all sources (excluding Drug/Medi-Cal), CONTRACTOR is required to have an agency-wide single audit, or CONTRACTOR may elect a program specific audit if all Federal funding is utilized for only one program. CONTRACTOR shall forward three (3) copies of the "Reporting Package" and completed "Data Collection Form", as described in OMB Circular A-133, to COUNTY. CONTRACTOR must also simultaneously submit one (1) copy of the "Reporting Package" and one (1) copy of the completed "Data Collection Form", to the Federal Audit Clearinghouse. The address of the Federal Audit Clearinghouse is:

Federal Audit Clearinghouse
Bureau of the Census
1201 E. 10th Street
Jacksonville, IN 47132

D. COUNTY Division of Audits, or designee, shall examine all Audits/Reviews submitted for conformance to these provisions. Should CONTRACTOR have other Federal financial assistance which would require it to have an agency-wide single audit done in conformance with OMB Circular A-133, COUNTY shall be allowed access to all financial and program records as COUNTY deems necessary to determine that the COUNTY program is in compliance with legal and contractual requirements.

E. Should any deficiencies be noted in the Audit/Review CONTRACTOR must submit an Action Plan with the Audit/Review detailing how the deficiencies will be addressed. CONTRACTOR shall correct all deficiencies within six months of the date that the Audit/Review is received by CONTRACTOR from its independent auditor, as required by Federal regulations.

F. Should any overpayment of funds be noted in the Audit/Review, CONTRACTOR shall reimburse COUNTY the amount of the overpayment within 30 days of the date of submission of the Audit/Review.

G. In the event that this Agreement is funded in whole or in part by State funds, the contracting parties shall be subject to examination and audit of the Auditor General for a period of three years after final payment under contract (Government Code, Section 8546.7).

XIII. CLAIMS FOR PAYMENT

A. During the term of this Agreement, COUNTY shall, except as herein provided, make provisional payments for services rendered during the preceding month upon the receipt of claims submitted by CONTRACTOR. CONTRACTOR shall submit a monthly claim on the forms and in accordance with the procedures prescribed by the COUNTY Ryan White CARE Program. Unless otherwise provided, claims shall be submitted to COUNTY no later than the tenth (10th) day of the month following the claim period, and COUNTY shall reimburse CONTRCTOR within 30 days after receipt of an appropriate and correct claim, except that DIRECTOR may withhold a percentage of the final claim until receipt by DIRECTOR of a complete and accurate final cost report.

exceed ten percent of the M ium Payment to Contractor through this A. ement at the time the advance is made. Advanced funds shall be offset against actual reported expenditures throughout the year or by other arrangements as approved by the DIRECTOR. For Agreements of less than a 12-month period, the one time advance amount may not exceed ten percent of a 12-month equivalent of the Maximum Payment to CONTRACTOR through this Agreement at the time the advance is made.

XVI. ELECTRONIC CAPABILITY

A. CONTRACTOR shall establish and maintain the ability to send and receive electronic (e-mail) communications with the COUNTY. CONTRACTOR shall provide the COUNTY with current primary contact information, including e-mail addresses.

B. CONTRACTOR shall submit computerized monthly invoices processed using one of the following software programs: Word Perfect; Word for Windows; Excel; Access; or Ryan White Careware.

XVII. CONTINUUM OF CARE RELATIONSHIPS

A. CONTRACTOR shall participate in the development of the Continuum of Care, including participation in the development of a Comprehensive Plan for the Eligible Metropolitan Area (EMA). This process will also require establishment and maintenance of cooperative working relationships with Ryan White Title I/II and other service providers within the region's Continuum of Care.

B. CONTRACTOR shall establish, maintain and document referral relationships with entities in the area served that constitute key points of entry to the health care system for individuals with HIV disease. Within the Sacramento EMA, these key points of entry include, but are not limited to, the Center for AIDS Research, Education and Services (CARES), University of California Davis Medical Center, local hospital emergency rooms, HIV disease counseling and testing sites, substance abuse and mental health treatment programs, detoxification centers, detention facilities, clinics regarding sexually transmitted diseases, homeless shelters, federally qualified health centers, and public health departments.

C. CONTRACTOR will conduct outreach efforts to reach low-income HIV+ individuals and inform them of service availability. Special emphasis will be placed on techniques to reach individuals who know their HIV+ status but are not currently in care.

COUNTY OF SACRAMENTO **COST REIMBURSEMENT AGREEMENT NO. 7275-07/08-709**

EXHIBIT G to Agreement
between the COUNTY OF SACRAMENTO,
hereinafter referred to as "COUNTY", and
EL DORADO COUNTY PUBLIC HEALTH DEPARTMENT,
hereinafter referred to as "CONTRACTOR"

CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

CONTRACTOR agrees to comply with 45 CFR Part 76.100 (Code of Federal Regulations), which provides that Federal funds may not be used for any contracted services, if CONTRACTOR is debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal department or agency.

I (We) certify to the best of my (our) knowledge and belief, that CONTRACTOR named below and its principals:

1. Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal department or agency;

2. Have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

3. Are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (2) of this certification; and

4. Have not within a 3-year period preceding this application/proposal/agreement had one or more public transactions (Federal, State, or local) terminated for cause or default.

5. Shall notify COUNTY within ten (10) days of receipt of notification that CONTRACTOR is subject to any proposed or pending debarment, suspension, indictments or termination of a public transaction.

6. Shall obtain a certification regarding debarment and suspension from all its subcontractors that will be funded through this Agreement.

7. Hereby agree to terminate immediately, any subcontractor's services that will be/are funded through this Agreement, upon discovery that the subcontractor is ineligible or voluntarily excluded from covered transactions by any Federal Department or agency.

EL DORADO COUNTY PUBLIC HEALTH DEPARTMENT

BY: _____ DATE: 6/29/07

VI. UNLISTED PROCEDURES (9999)

A. Complete description of the proposed treatment and the need for service must be documented.

B. The fee requested must be listed and is subject to review by County representatives.

C. Non-emergency unlisted procedures require prior authorization.

VII. COVERED PROCEDURES

A. DIAGNOSTIC

Procedure 0110	Examination, initial episode of treatment only. Radiographs are covered when taken in compliance with state and federal regulations for radiation hygiene, and when they fully depict subject teeth and associated structures by standard illumination, and are appropriate to the symptoms and conditions of the patient.
Procedure 0120	Periodic oral examination limited to any two examinations (0110, 0120, 0130) per contract year.
Procedure 0210	Intraoral, complete series when medically necessary and in accepted standards of dental practice. Limited to once in a three (3) year period.
Procedure 0230	Intraoral periapical, each additional film (maximum ten films).
Procedure 0240	Intraoral, occlusal film.
Procedure 0272	Bitewings, two films. Limited to once per contract year.
Procedure 0274	Bitewings, four films. Limited to once per contract year.
Procedure 0330	Panographic-type film, single film. Limited to once every three (3) years.
Procedure 0470	Diagnostic casts.

B. PREVENTIVE – Covered only when in conjunction with restorative procedures and limited to two (2) times per contract year.

Procedure 1110	Prophylaxis – adult, limited to two (2) times per contract year.
Procedure 1120	Prophylaxis – child, limited to two (2) times per contract year.
Procedure 1201	Topical application of fluoride (including prophylaxis) – child.
Procedure 1203	Topical application of fluoride (prophylaxis not included) – child.
Procedure 1204	Topical application of fluoride (including prophylaxis) – adult.
Procedure 1205	Topical application of fluoride (prophylaxis not included) – adult.
Procedure 1351	Sealant – per tooth, children only.

C. RESTORATIVE DENTISTRY

1. The program provides temporary restoration, amalgam, composite, or plastic restorations for treatment of caries. If the tooth can be restored with such material, any crown or jacket is not covered.

2. Laboratory processed crowns are benefits for permanent anterior teeth and permanent posterior teeth once in a five (5) year period.

Procedure 2954 Prefabricated post and core, in addition to crown.

Procedure 2970 Temporary crown or stainless steel band.

D. ENDODONTICS – GENERAL POLICIES

1. Includes those procedures when complete root canal filling on permanent teeth:

   a. Root canal therapy is a covered benefit, if medically necessary – tooth is non-vital. The prognosis of the affected tooth and other remaining teeth will be evaluated in considering root canal therapy.

   b. Authorization and payment for root canal treatment includes, but is not limited to, any of the following procedures:

      Any incision and drainage necessary on relation to the root canal therapy.

      Vitality test.

      Radiographs required during treatment.

      Culture.

      Medicated treatment.

      Final filling of canals.

      Final treatment radiographs.

   c. Necessary retreatment and postoperative care within a 90-day period is included in the reimbursement fee for the root canal therapy.

   d. Root canal therapy must be completed prior to payment. Date of service on the claim for payment must reflect the final completion date.

2. Emergency root canal treatment may be done when any of the following conditions exist and **documentation substantiates the need:**

   a. Failure of a palliative treatment to relieve the acute distress of the patient.

   b. When a tooth has been accidentally evulsed.

   c. When there has been a fracture of the crown of a tooth exposing the pulpal tissue.

3. The prognosis of the affected tooth, other remaining teeth, and the type of restorations allowable will be evaluated in considering requested root canal therapy.

4. Extraction may be suggested for a tooth with a fractured root, external or internal resorption, or one that is easily replaced by addition to an existing removable dental appliance.

Procedure 3110 Pulp cap – direct (excluding final restoration).

Procedure 3120 Pulp cap – indirect (excluding final restoration).

Procedure 3220 Therapeutic pulpotomy (excluding final restoration).

Procedure 3310 Anterior root canal therapy (excluding final restoration).

Procedure 3320 Bicuspid root canal therapy (excluding final restoration).

Procedure 3330 Molar root canal therapy (excluding final restoration).

f. The patient has been without dentures for at least five (5) years and is currently functioning without dentures.

4. Immediate dentures may be authorized when conditions including but not limited to the following exist:

a. Extensive or rampant caries are exhibited.

b. Severe periodontal involvement is indicated.

i. When the clinical exam shows excessive mobility and severe gingivitis.

ii. When tooth mobility is not grossly evident and when the gingival tissues are not severely involved, consideration should be given to a more conservative treatment and denture request denied.

c. Numerous teeth are missing and masticating ability has been diminished.

i. Where there is not capability of any posterior occlusion with existing dentition.

ii. When a functional, although minimal, occlusion exists, the urgent need for prosthesis should be carefully evaluated.

5. Requests for replacement dentures shall include adequate supportive documentation and shall be preauthorized. Replacement dentures may be authorized more often than once in a five (5) year period when:

a. Catastrophic loss of denture.

b. Surgical or traumatic loss of oral-facial anatomic structures.

c. Replacement of existing dentures.

i. When there has been a complete deterioration of the denture base or teeth.

ii. When there has been a complete loss of retentive ability, vertical dimension, or balanced occlusion of existing dentures.

6. Requests for dentures for the long-standing edentulous patient will be denied.

7. A removable Partial denture is covered when necessary for the replacement of anterior teeth only.

8. A covered removable partial denture may be authorized only once in a five (5) year period except to:

a. Prevent a significant disability.

b. Replace a covered removable dental prosthesis which has been lost or destroyed due to circumstances beyond the beneficiary's control.

Procedure 5110 Complete denture - maxillary.

Procedure 5120 Complete denture – mandibular.

Procedure 5130 Immediate denture – maxillary.

Procedure 5140 Immediate denture – mandibular.

Procedure 5211 Maxillary partial denture – resin base (including any conventional clasps, rests and teeth).

Procedure 5212 Mandibular partial denture – resin base (including any conventional clasps, rests and teeth).

Procedure 5821	Interim partial denture (mandibular).
Procedure 5850	Tissue conditioning – maxillary.
Procedure 5851	Tissue conditioning – mandibular.

G. PROSTHETICS - FIXED

Procedure 6210	Pontic-cast with high noble metal.
Procedure 6240	Pontic-porcelain with high noble metal.
Procedure 6250	Pontic-resin with high noble metal.
Procedure 6750	Bridge crown-porcelain with high noble metal.
Procedure 6790	Bridge crown-full case with high noble metal.
Procedure 6930	Re-cement bridge.
Procedure 6940	Stress breaker.
Procedure 6970	Cast post and core in addition to bridge crown (endodontically treated tooth).
Procedure 6971	Cast post as part of bridge crown.
Procedure 6972	Prefabricated post and core in addition to bridge crown (endodontically treated tooth).
Procedure 6980	Repair fixed bridge.
Procedure 6999	Unspecified fixed prosthodontic procedure, by report.

H. ORAL SURGERY

1. EXTRACTIONS – GENERAL POLICIES

a. Diagnostic x-rays fully depicting subject tooth (teeth) are usually required for all intraoral surgical procedures. (See specific procedure code for details)

b. The extraction of asymptomatic teeth is not a benefit.

The following instances may be justified as being symptomatic:

i. Teeth which are involved with a cyst, tumor, or neoplasm.

ii. The extraction of all remaining teeth in preparation for a full prosthesis.

iii. A malaligned tooth that causes intermittent gingival inflammation.

iv. Perceptible radiologic pathology that fails to elicit symptoms.

c. By repot procedures may be used when the provider has encountered unforeseen complications which are not usually considered normal to the particular procedure listed.

Procedure 7110	Removal of erupted tooth, uncomplicated, first tooth
Procedure 7120	Removal of erupted tooth (teeth), uncomplicated, each additional tooth.
Procedure 7130	Removal of root or root tip.

Procedure 9440	Professional visit after regular office hours or to bedside.
Procedure 9930	Post-operative visit, complications (post surgical *e.g.*, osteitis).
Procedure 9940	Occlusal guard, by report.
Procedure 9951	Occlusal adjustment – limited.
Procedure 9952	Occlusal adjustment – complete.

J. UNLISTED PROCEDURES

Procedure 9999	Unlisted procedures; requires definition and requires prior authorization by County for non-emergency procedures..

VIII. NOT COVERED PROCEDURES

The following are not benefits under the program:

A. DIAGNOSTIC and PREVENTIVE

1. Preventive control program, including fissure sealant, prophylactic fillings, oral hygiene instruction, dietary instruction and prophylaxis when not in conjunction with restorative treatment. (Prophy's can be obtained at Sacramento City College Dental Hygiene Department).

B. ORAL SURGERY

1. Experimental procedures.
2. Asymptomatic extractions.
3. Surgical correction of the maxilla and mandible by grafts for denture retention.
4. Surgical treatment of temporomandibular joint disturbances.
5. Surgical treatment of prognathism or retrognathism.
6. Surgical treatment to correct congenital or developmental malformation.

C. PRESCRIBED DRUGS – Reimbursement for prescription drugs is not covered unless there is no other payor source and is limited to only those drugs that are currently prescribed by the dental community for dental related needs.

D. ORTHODONTIC SERVICES

E. RESTORATIVE DENTISTRY

1. Full mouth reconstruction procedure.
2. Cosmetic procedure and restorations (other than those for replacement of structure loss from caries) that are necessary to alter, restore or maintain occlusion. These include:
   a. Increasing vertical dimension.
   b. Replacing or stabilizing tooth structure loss by attrition.
   c. Realignment of teeth.
   d. Periodontal splinting.
   e. Gnathologic recordings.

COUNTY OF SACRAMENTO **COST REIMBURSEMENT AGREEMENT NO. 7275-07/08-709**

ATTACHMENT B
Fee Schedule

CODE	DESCRIPTION	UOS	FEE
00110	Initial oral examination	0.4	$41.20
00120	Periodic oral examination	0.3	$30.90
00210	Intraoral-complete series (including bitewings)	0.7	$72.10
00220	Intraoral-periapical-first film	0.2	$20.60
00230	Intraoral-periapical-each additional film	0.1	$10.30
00240	Intraoral-occlusal film	0.3	$30.90
00270	Bitewing-single film	0.2	$20.60
00272	Bitewing-two films	0.3	$30.90
00274	Bitewing-four films	0.4	$41.20
00330	Panoramic film	0.6	$61.80
00470	Diagnostic casts	0.6	$61.80
01110	Prophylaxis-adult	0.6	$61.80
01120	Prophylaxis-child	0.5	$51.50
01201	Topical application of fluoride (including prophylaxis)-child	0.6	$61.80
01203	Topical application of fluoride (prophylaxis not included)-child	0.2	$20.60
01204	Topical application of fluoride (prophylaxis not included)-adult	0.3	$30.90
01205	Topical application of fluoride (including prophylaxis)-adult	0.7	$72.10
01351	Sealant-per tooth	0.3	$30.90
02110	Amalgam-one surface, primary	0.6	$61.80
02120	Amalgam-two surfaces, primary	0.7	$72.10
02130	Amalgam-three surfaces, primary	0.9	$92.70
02131	Amalgam-four or more surfaces, primary	1.0	$103.00
02140	Amalgam-one surface, permanent	0.7	$72.10
02150	Amalgam-two surfaces, permanent	0.9	$92.70
02160	Amalgam-three surfaces, permanent	1.0	$103.00
02161	Amalgam-four or more surfaces, permanent	1.2	$123.60
02330	Resin-one surface, anterior	0.9	$92.70
02331	Resin-two surfaces, anterior	1.0	$103.00
02332	Resin-three surfaces, anterior	1.2	$123.60
02335	Resin-four or more surfaces or involving incisal angle (anterior)	1.7	$175.10
02750	Crown-porcelain fused to high noble metal	7.8	$803.40
02751	Crown-porcelain fused to predominantly base metal	6.7	$690.10
02752	Crown-porcelain fused to noble metal	7.1	$731.30
02790	Crown-full cast high noble metal	7.0	$721.00
02791	Crown-full cast predominantly base metal	6.1	$628.30

05710	Rebase complete maxillary denture	3.4	$350.20
05711	Rebase complete mandibular denture	3.4	$350.20
05720	Rebase maxillary partial denture	3.4	$350.20
05721	Rebase mandibular partial denture	3.5	$360.50
05730	Reline complete maxillary denture (chairside)	1.7	$175.10
05731	Reline complete mandibular denture (chairside)	1.7	$175.10
05740	Reline maxillary partial denture (chairside)	1.7	$175.10
05741	Reline mandibular partial denture (chairside)	1.7	$175.10
05750	Reline complete maxillary denture (laboratory)	2.6	$267.80
05751	Reline complete mandibular denture (laboratory)	2.5	$257.50
05760	Reline maxillary partial denture (laboratory)	2.5	$257.50
05761	Reline mandibular partial denture (laboratory)	2.5	$257.50
05810	Interim complete denture (maxillary)	4.3	$442.90
05811	Interim complete denture (mandibular)	4.3	$442.90
05820	Interim partial denture (maxillary)	3.7	$381.10
05821	Interim partial denture (mandibular)	3.7	$381.10
05850	Tissue conditioning (maxillary)	1.0	$103.00
05851	Tissue conditioning (mandibular)	1.0	$103.00
06210	Pontic-cast high noble metal	7.0	$721.00
06211	Pontic-cast predominantly base metal	6.1	$628.30
06212	Ponic-cast noble metal	6.7	$690.10
06240	Pontic-porcelain fused to high noble metal	7.9	$813.70
06241	Pontic-porcelain fused to predominantly base metal	6.7	$690.10
06242	Pontic-porcelain fused to noble metal	7.0	$721.00
06750	Crown-porcelain fused to high noble metal	7.9	$813.70
06751	Crown-porcelain fused to predominantly base metal	6.6	$679.80
06752	Crown-porcelain fused to noble metal	7.0	$721.00
06790	Crown-full cast high noble metal	7.1	$731.30
06791	Crown-full cast predominantly base metal	6.3	$648.90
06792	Crown-full cast noble metal	7.0	$721.00
06930	Recement fixed partial denture	1.0	$103.00
06940	Stress breaker	2.6	$267.80
06970	Cast post and core in addition to fixed partial denture retainer	2.9	$298.70
06971	Cast post and core as part of a fixed partial denture retainer	2.9	$298.70
06972	Prefabricated post and core in addition to fixed partial denture retainer	2.3	$236.90
06973	Core build up for retainer, including any pins	1.8	$185.40
06980	Fixed partial denture repair, by report	5.5	$566.50
07110	Single tooth extraction	0.8	$82.40
07120	Each additional tooth extraction	0.8	$82.40
07130	Root removal-exposed roots	1.0	$103.00
07210	Surgical removal of erupted tooth requiring elevation of flap and/or removal of bone	1.3	$133.90
07220	Removal of impacted tooth-soft tissue	1.5	$154.50
07230	Removal of impacted tooth-partial bony	2.0	$206.00
07240	Removal of impacted tooth-complete bony	3.0	$309.00

COUNTY OF SACRAMENTO **NEGOTIATED RATE AGREEMENT NO. 7275-07/08-709**

EXHIBIT F to Agreement
between the COUNTY OF SACRAMENTO,
hereinafter referred to as "COUNTY", and
EL DORADO COUNTY PUBLIC HEALTH DEPARTMENT,
hereinafter referred to as "CONTRACTOR"

THE RYAN WHITE TREATMENT MODERNIZATION ACT:
A COMPILATION OF
THE RYAN WHITE TREATMENT MODERNIZATION ACT OF 2006 (Pub. L. 109-415)
THE RYAN WHITE CARE ACT OF 1990 (Pub. L. 101-381),
AS AMENDED BY THE RYAN WHITE CARE ACT AMENDMENTS OF 1996 (Pub. L. 104-146)
AND THE
RYAN WHITE CARE ACT AMENDMENTS OF 2000 (Pub. L. 106-345)

TITLE I--EMERGENCY RELIEF FOR ELIGIBLE AREAS

SEC. 101. ESTABLISHMENT OF PROGRAM; GENERAL ELIGIBILITY FOR GRANTS.

(a) In General.--Section 2601 of the Public Health Service Act (42 U.S.C. 300ff-11) is amended by striking subsections (b) through (d) and inserting the following:

``(b) Continued Status as Eligible Area.--Notwithstanding any other provision of this section, a metropolitan area that is an eligible area for a fiscal year continues to be an eligible area until the metropolitan area fails, for three consecutive fiscal years--

``(1) to meet the requirements of subsection (a); and

``(2) to have a cumulative total of 3,000 or more living cases of AIDS (reported to and confirmed by the Director of the Centers for Disease Control and Prevention) as of December 31 of the most recent calendar year for which such data is available.

``(c) Boundaries.--For purposes of determining eligibility under this part--

``(1) with respect to a metropolitan area that received funding under this part in fiscal year 2006, the boundaries of such metropolitan area shall be the boundaries that were in effect for such area for fiscal year 1994; or

``(2) with respect to a metropolitan area that becomes eligible to receive funding under this part in any fiscal year after fiscal year 2006, the boundaries of such metropolitan area shall be the boundaries that are in effect for such area when such area initially receives funding under this part.''.

(b) Technical and Conforming Amendments.--Section 2601(a) of the Public Health Service Act (42 U.S.C. 300ff-11(a)) is amended--

(1) by striking ``through (d)'' and inserting ``through (c)''; and

(2) by inserting ``and confirmed by'' after ``reported to''.

(c) Definition of Metropolitan Area.--Section 2607(2) of the Public Health Service Act (42 U.S.C. 300ff-17(2)) is amended--

(1) by striking ``area referred'' and inserting ``area that is referred''; and

(2) by inserting before the period the following: ``, and that has a population of 50,000 or more individuals''.

SEC. 102. TYPE AND DISTRIBUTION OF GRANTS; FORMULA GRANTS.

Secretary a plan for making the transition to sufficiently accurate and reliable names-based reporting of living non-AIDS cases of HIV; or

``(bb) all statutory changes necessary to provide for sufficiently accurate and reliable reporting of such cases had been made; and

``(II) the State had agreed that, by April 1, 2008, the State will begin accurate and reliable names-based reporting of such cases, except that

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such agreement is not required to provide that, as of such date, the system for such reporting be fully sufficient with respect to accuracy and reliability throughout the area.

``(iv) Requirement <<NOTE: Applicability. Deadline.>> for exemption as of fiscal year 2008.--For each of the fiscal years 2008 through 2010, an exemption under clause (ii) for an eligible area applies only if, as of April 1, 2008, the State in which the area is located is substantially in compliance with the agreement under clause (iii)(II).

``(v) Progress toward names-based reporting.--For fiscal year 2009, the Secretary may terminate an exemption under clause (ii) for an eligible area if the State in which the area is located submitted a plan under clause (iii)(I)(aa) and the Secretary determines that the State is not substantially following the plan.

``(vi) Counting of cases in areas with exemptions.--

``(I) In general.--With respect to an eligible area that is under a reporting system for living non-AIDS cases of HIV that is not names-based (referred to in this subparagraph as `code-based reporting'), the Secretary shall, for purposes of this subparagraph, modify the number of such cases reported for the eligible area in order to adjust for duplicative reporting in and among systems that use code-based reporting.

``(II) Adjustment rate.--The adjustment rate under subclause (I) for an eligible area shall be a reduction of 5 percent in the number of living non-AIDS cases of HIV reported for the area.

``(vii) Multiple <<NOTE: Applicability.>> political jurisdictions.--With respect to living non-AIDS cases of HIV, if an eligible area is not entirely within one political jurisdiction and as a result is subject to more than one reporting system for purposes of this subparagraph:

``(I) Names-based reporting under clause (i) applies in a jurisdictional portion of the area, or an exemption under clause (ii) applies in such portion (subject to applicable

``(D) Code-based areas; limitation on increase in grant .--

``(i) In general.--

For <<NOTE: Applicability.>> each of the fiscal years 2007 through 2009, if code-based reporting (within the meaning of subparagraph (C)(vi)) applies in an eligible area or any portion thereof as of the beginning of the fiscal year involved, then notwithstanding any other provision of this paragraph, the amount of the grant pursuant to this paragraph for such area for such fiscal year may not--

``(I) for fiscal year 2007, exceed by more than 5 percent the amount of the grant for the area that would have been made pursuant to this paragraph and paragraph (4) for fiscal year 2006 (as such paragraphs were in effect for such fiscal year) if paragraph (2) (as so in effect) had been applied by substituting `66\2/3\ percent' for `50 percent'; and

``(II) for each of the fiscal years 2008 and 2009, exceed by more than 5 percent the amount of the grant pursuant to this paragraph and paragraph (4) for the area for the preceding fiscal year.

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``(ii) Use of amounts involved.--For each of the fiscal years 2007 through 2009, amounts available as a result of the limitation under clause (i) shall be made available by the Secretary as additional amounts for grants pursuant to subsection (b) for the fiscal year involved, subject to paragraph (4) and section 2610(d)(2).''.

(d) Hold Harmless.--Section 2603(a) of the Public Health Service Act (42 U.S.C. 300ff-13(a)) is amended--

(1) in paragraph (3)(A)--

(A) in clause (ii), by striking the period at the end and inserting a semicolon; and

(B) by inserting after and below clause (ii) the following:

``which product shall then, as applicable, be increased under paragraph (4).''.

(2) by amending paragraph (4) to read as follows:

``(4) Increases in grant.--

``(A) In general.--For each eligible area that received a grant pursuant to this subsection for fiscal year 2006, the Secretary shall, for each of the fiscal years 2007 through 2009, increase the amount of the grant made pursuant to paragraph (3) for the area to ensure that the amount of the grant for the fiscal year involved is not less than the following amount, as applicable to such fiscal year:

``(i) For fiscal year 2007, an amount equal to 95 percent of the amount of the grant that would have been made pursuant to paragraph (3) and this paragraph for fiscal year 2006 (as such paragraphs were in effect for such fiscal year) if paragraph (2) (as so in effect) had been applied by substituting `66\2/3\ percent' for `50 percent'.

``(ii) For each of the fiscal years 2008 and 2009, an amount equal to 100 percent of the amount

determined under section 2602(b)(4) or other community input process as defined under section 2609(d)(1)(A).

``(ii) An increasing need for HIV/AIDS-related services, including relative rates of increase in the number of cases of HIV/AIDS.

``(iii) The relative rates of increase in the number of cases of HIV/AIDS within new or emerging subpopulations.

``(iv) The current prevalence of HIV/AIDS.

``(v) Relevant factors related to the cost and complexity of delivering health care to individuals with HIV/AIDS in the eligible area.

``(vi) The impact of co-morbid factors, including co-occurring conditions, determined relevant by the Secretary.

``(vii) The prevalence of homelessness.

``(viii) The prevalence of individuals described under section 2602(b)(2)(M).

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``(ix) The relevant factors that limit access to health care, including geographic variation, adequacy of health insurance coverage, and language barriers.

``(x) The impact of a decline in the amount received pursuant to subsection (a) on services available to all individuals with HIV/AIDS identified and eligible under this title.''; and

(C) by striking subparagraphs (C) and (D) and inserting the following:

``(C) Priority in making grants.--The Secretary shall provide funds under this subsection to an eligible area to address the decline or disruption of all EMA-provided services related to the decline in the amounts received pursuant to subsection (a) consistent with the grant award for the eligible area for fiscal year 2006, to the extent that the factor under subparagraph (B)(x) (relating to a decline in funding) applies to the eligible area.''.

SEC. 104. TIMEFRAME FOR OBLIGATION AND EXPENDITURE OF GRANT FUNDS.

Section 2603 of the Public Health Service Act (42 U.S.C. 300ff-13) is amended--

(1) by redesignating subsection (c) as subsection (d);

(2) by inserting after subsection (b) the following:

``(c) Timeframe <<NOTE: Effective dates.>> for Obligation and Expenditure of Grant Funds.--

``(1) Obligation by end of grant year.--Effective for fiscal year 2007 and subsequent fiscal years, funds from a grant award made pursuant to subsection (a) or (b) for a fiscal year are available for obligation by the eligible area involved through the end of the one-year period beginning on the date in such fiscal year on which funds from the award first become available to the area (referred to in this subsection as the `grant year for the award'), except as provided in paragraph (3)(A).

``(2) Supplemental grants; cancellation of unobligated balance of grant award.--Effective for fiscal year 2007 and subsequent fiscal years, if a grant award made pursuant to subsection (b) for an eligible area for a fiscal year has an unobligated balance as of the end of the grant year for the award--

``(A) the Secretary shall cancel that unobligated

balance, the amount of the grant under such subsection for the first fiscal year beginning after the fiscal year in which the Secretary obtains the information necessary for determining that such balance was unobligated as of the end of the grant year (which requirement for a reduction applies without regard to whether a waiver under subparagraph (A) has been approved with respect to such balance); and

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``(II) the grant funds involved in such reduction shall be made available by the Secretary as additional funds for grants pursuant to subsection (b) for such first fiscal year, subject to subsection (a)(4) and section 2610(d)(2);

except that this clause does not apply to the eligible area if the amount of the unobligated balance was 2 percent or less.

``(ii) Relation to increases in grant.--A reduction under clause (i) for an eligible area for a fiscal year may not be taken into account in applying subsection (a)(4) with respect to the area for the subsequent fiscal year.''; and

(3) by adding at the end the following:

``(e) Report on the Awarding of Supplemental Funds.--Not later than 45 days after the awarding of supplemental funds under this section, the Secretary shall submit to Congress a report concerning such funds. Such report shall include information detailing--

``(1) the total amount of supplemental funds available under this section for the year involved;

``(2) the amount of supplemental funds used in accordance with the hold harmless provisions of subsection (a)(4);

``(3) the amount of supplemental funds disbursed pursuant to subsection (b)(2)(C);

``(4) the disbursement of the remainder of the supplemental funds after taking into account the uses described in paragraphs (2) and (3); and

``(5) the rationale used for the amount of funds disbursed as described under paragraphs (2), (3), and (4).''.

SEC. 105. USE OF AMOUNTS.

Section 2604 of the Public Health Service Act (42 U.S.C. 300ff-14) is amended to read as follows:

``SEC. 2604. USE OF AMOUNTS.

``(a) Requirements.--The Secretary may not make a grant under section 2601(a) to the chief elected official of an eligible area unless such political subdivision agrees that--

``(1) subject to paragraph (2), the allocation of funds and services within the eligible area will be made in accordance with the priorities established, pursuant to section 2602(b)(4)(C), by the HIV health services planning council that serves such eligible area;

``(2) funds provided under section 2601 will be expended only for--

``(A) core medical services described in subsection (c);

defined under section 2614(c).
``(K) Mental health services.
``(L) Substance abuse outpatient care.
``(M) Medical case management, including treatment adherence services.

``(d) Support Services.--
``(1) In general.--For purposes of this section, the term `support services' means services, subject to the approval of

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the Secretary, that are needed for individuals with HIV/AIDS to achieve their medical outcomes (such as respite care for persons caring for individuals with HIV/AIDS, outreach services, medical transportation, linguistic services, and referrals for health care and support services).
``(2) Medical outcomes.--In this subsection, the term `medical outcomes' means those outcomes affecting the HIV-related clinical status of an individual with HIV/AIDS.

``(e) Early Intervention Services.--
``(1) In general.--For purposes of this section, the term `early intervention services' means HIV/AIDS early intervention services described in section 2651(e), with follow-up referral provided for the purpose of facilitating the access of individuals receiving the services to HIV-related health services. The entities through which such services may be provided under the grant include public health departments, emergency rooms, substance abuse and mental health treatment programs, detoxification centers, detention facilities, clinics regarding sexually transmitted diseases, homeless shelters, HIV/AIDS counseling and testing sites, health care points of entry specified by eligible areas, federally qualified health centers, and entities described in section 2652(a) that constitute a point of access to services by maintaining referral relationships.
``(2) Conditions.--With <<NOTE: Applicability.>> respect to an entity that proposes to provide early intervention services under paragraph (1), such paragraph shall apply only if the entity demonstrates to the satisfaction of the chief elected official for the eligible area involved that--
``(A) Federal, State, or local funds are otherwise inadequate for the early intervention services the entity proposes to provide; and
``(B) the entity will expend funds pursuant to such paragraph to supplement and not supplant other funds available to the entity for the provision of early intervention services for the fiscal year involved.

``(f) Priority for Women, Infants, Children, and Youth.--
``(1) In general.--For the purpose of providing health and support services to infants, children, youth, and women with HIV/AIDS, including treatment measures to prevent the perinatal transmission of HIV, the chief elected official of an eligible area, in accordance with the established priorities of the planning council, shall for each of such populations in the eligible area use, from the grants made for the area under section 2601(a) for a fiscal year, not less than the percentage constituted by the ratio of the population involved (infants, children, youth, or women in such area) with HIV/AIDS to the general population in such area of individuals with HIV/AIDS.
``(2) Waiver.--With respect to the population involved, the Secretary may provide to the chief elected official of an eligible area a waiver of the requirement of paragraph (1) if such official demonstrates to the satisfaction of the Secretary

and financial reports, and compliance with grant conditions and audit requirements; and

``(B) all activities associated with the grantee's contract award procedures, including the activities carried out by

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the HIV health services planning council as established under section 2602(b), the development of requests for proposals, contract proposal review activities, negotiation and awarding of contracts, monitoring of contracts through telephone consultation, written documentation or onsite visits, reporting on contracts, and funding reallocation activities.

``(4) Subcontractor administrative activities.--For the purposes of this subsection, subcontractor administrative activities include--

``(A) usual and recognized overhead activities, including established indirect rates for agencies;

``(B) management oversight of specific programs funded under this title; and

``(C) other types of program support such as quality assurance, quality control, and related activities.

``(5) Clinical quality management.--

``(A) Requirement.--The chief elected official of an eligible area that receives a grant under this part shall provide for the establishment of a clinical quality management program to assess the extent to which HIV health services provided to patients under the grant are consistent with the most recent Public Health Service guidelines for the treatment of HIV/AIDS and related opportunistic infection, and as applicable, to develop strategies for ensuring that such services are consistent with the guidelines for improvement in the access to and quality of HIV health services.

``(B) Use of funds.--

``(i) In general.--From amounts received under a grant awarded under this subpart for a fiscal year, the chief elected official of an eligible area may use for activities associated with the clinical quality management program required in subparagraph (A) not to exceed the lesser of--

``(I) 5 percent of amounts received under the grant; or

``(II) $3,000,000.

``(ii) Relation to limitation on administrative expenses.--The costs of a clinical quality management program under subparagraph (A) may not be considered administrative expenses for purposes of the limitation established in paragraph (1).

``(i) Construction.--A chief elected official may not use amounts received under a grant awarded under this part to purchase or improve land, or to purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or to make cash payments to intended recipients of services.''.

SEC. 106. ADDITIONAL AMENDMENTS TO PART A.

(a) Reporting of Cases.--Section 2601(a) of the Public Health Service Act (42 U.S.C. 300ff-11(a)) is amended by striking ``for the most recent period'' and inserting ``during the most recent period''.

(b) Planning Council Representation.--Section 2602(b)(2)(G) of the Public Health Service Act (42 U.S.C. 300ff-12(b)(2)(G)) is amended by

``(b) Transitional Areas.--For purposes of this section, the term `transitional area' means, subject to subsection (c), a metropolitan area for which there has been reported to and confirmed by the Director of the Centers for Disease Control and Prevention a cumulative total of at least 1,000, but fewer than 2,000, cases of AIDS during the most recent period of 5 calendar years for which such data are available.

``(c) Certain Eligibility Rules.--

``(1) Fiscal year 2007.--With respect to grants under subsection (a) for fiscal year 2007, a metropolitan area that received funding under subpart I for fiscal year 2006 but does not for fiscal year 2007 qualify under such subpart as an eligible area and does not qualify under subsection (b) as a transitional area shall, notwithstanding subsection (b), be considered a transitional area.

``(2) Continued status as transitional area.--

``(A) In general.--Notwithstanding subsection (b), a metropolitan area that is a transitional area for a fiscal year continues, except as provided in subparagraph (B), to be a transitional area until the metropolitan area fails, for three consecutive fiscal years--

``(i) to qualify under such subsection as a transitional area; and

``(ii) to have a cumulative total of 1,500 or more living cases of AIDS (reported to and confirmed by the Director of the Centers for Disease Control and Prevention) as of December 31 of the most recent calendar year for which such data is available.

``(B) Exception regarding status as eligible area.--Subparagraph (A) does not apply for a fiscal year if the metropolitan area involved qualifies under subpart I as an eligible area.

``(d) Application of Certain Provisions of Subpart I.--

``(1) Administration; planning council.--

``(A) In general.--The provisions of section 2602 apply with respect to a grant under subsection (a) for a transitional area to the same extent and in the same manner as such provisions apply with respect to a grant under subpart I for an eligible area, except that, subject to subparagraph (B), the chief elected official of the transitional area may elect not to comply with the provisions of section 2602(b) if the official provides documentation to the Secretary that details the process used to obtain community input (particularly from those with HIV) in the transitional area for formulating the overall plan for priority setting and allocating funds from the grant under subsection (a).

``(B) Exception.--For each of the fiscal years 2007 through 2009, the exception described in subparagraph (A) does not apply if the transitional area involved received funding under subpart I for fiscal year 2006.

``(2) Type and distribution of grants; timeframe for obligation and expenditure of grant funds.--

``(A) Formula grants; supplemental grants.--The provisions of section 2603 apply with respect to grants under subsection (a) to the same extent and in the same

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manner as such provisions apply with respect to grants under subpart I, subject to subparagraphs (B) and (C).

``(B) Formula grants; increase in grant.--For purposes of subparagraph (A), section 2603(a)(4) does not apply.

or (2)(A) of subsection (b) of this section for the first such subsequent year of not being an eligible area is deemed to be reduced by an amount equal to the amount of the grant made pursuant to section 2603(a) for the metropolitan area for the preceding fiscal year; and

``(ii)(I) if the metropolitan area qualifies for such first subsequent fiscal year as a transitional area under 2609, the amount reserved under paragraph (1)(B) or (2)(B) of subsection (b) for such fiscal year is deemed to be increased by an amount equal to the amount of the reduction under subparagraph (A) for such year; or

``(II) if the metropolitan area does not qualify for such first subsequent fiscal year as a transitional area under 2609, an amount equal to the amount of such reduction is, notwithstanding subsection (a), transferred and made available for grants pursuant to section 2618(a)(1), in addition to amounts available for such grants under section 2623; and

``(B) if a transfer under subparagraph (A)(ii)(II) is made with respect to the metropolitan area for such first subsequent fiscal year, then--

``(i) the amount reserved under paragraph (1)(A) or (2)(A) of subsection (b) of this section for such year is deemed to be reduced by an additional $500,000; and

``(ii) an amount equal to the amount of such additional reduction is, notwithstanding subsection (a), transferred and made available for grants pursuant to section 2618(a)(1), in addition to amounts available for such grants under section 2623.

``(2) If a metropolitan area is a transitional area under section 2609 for a fiscal year, but for a subsequent fiscal year ceases to be a transitional area by reason of section 2609(c)(2) (and does not qualify for such subsequent fiscal year as an eligible area under subpart I)--

``(A) the amount reserved under subsection (b)(2)(B) of this section for the first such subsequent fiscal year of not being a transitional area is deemed to be reduced by an amount equal to the total of--

``(i) the amount of the grant that, pursuant to section 2603(a), was made under section 2609(d)(2)(A) for the metropolitan area for the preceding fiscal year; and

``(ii) $500,000; and

``(B) an amount equal to the amount of the reduction under subparagraph (A) for such year is, notwithstanding subsection (a), transferred and made available for grants pursuant to section 2618(a)(1), in addition to amounts available for such grants under section 2623.

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``(3) If a metropolitan area is a transitional area under section 2609 for a fiscal year, but for a subsequent fiscal year qualifies as an eligible area under subpart I--

``(A) the amount reserved under subsection (b)(2)(B) of this section for the first such subsequent fiscal year of becoming an eligible area is deemed to be reduced by an amount equal to the amount of the grant that, pursuant to section 2603(a), was made under section 2609(d)(2)(A) for the metropolitan area for the preceding fiscal year; and

``(B) the amount reserved under subsection (b)(2)(A) for such fiscal year is deemed to be increased by an

Assistance Program services under section 2616; and

``(ii) core medical services are available to all individuals with HIV/AIDS identified and eligible under this title.

``(B) Notification of waiver status.--When informing a State that a grant under section 2611 is being made to the State for a fiscal year, the Secretary shall inform the State whether a waiver under subparagraph (A) is in effect for the fiscal year.

``(3) Core medical services.--For purposes of this subsection, the term `core medical services', with respect to an individual infected with HIV/AIDS (including the co-occurring conditions of the individual) means the following services:

``(A) Outpatient and ambulatory health services.

``(B) AIDS Drug Assistance Program treatments in accordance with section 2616.

``(C) AIDS pharmaceutical assistance.

``(D) Oral health care.

``(E) Early intervention services described in subsection (d).

``(F) Health insurance premium and cost sharing assistance for low-income individuals in accordance with section 2615.

``(G) Home health care.

``(H) Medical nutrition therapy.

``(I) Hospice services.

``(J) Home and community-based health services as defined under section 2614(c).

``(K) Mental health services.

``(L) Substance abuse outpatient care.

``(M) Medical case management, including treatment adherence services.

``(c) Support Services.--

``(1) In general.--For purposes of this subsection, the term `support services' means services, subject to the approval of the Secretary, that are needed for individuals with HIV/AIDS to achieve their medical outcomes (such as respite care for persons caring for individuals with HIV/AIDS, outreach services, medical transportation, linguistic services, and referrals for health care and support services).

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``(2) Definition of medical outcomes.--In this subsection, the term `medical outcomes' means those outcomes affecting the HIV-related clinical status of an individual with HIV/AIDS.

``(d) Early Intervention Services.--

``(1) In general.--For purposes of this section, the term `early intervention services' means HIV/AIDS early intervention services described in section 2651(e), with follow-up referral provided for the purpose of facilitating the access of individuals receiving the services to HIV-related health services. The entities through which such services may be provided under the grant include public health departments, emergency rooms, substance abuse and mental health treatment programs, detoxification centers, detention facilities, clinics regarding sexually transmitted diseases, homeless shelters, HIV/AIDS counseling and testing sites, health care points of entry specified by States, federally qualified health centers, and entities described in section 2652(a) that constitute a point of access to services by maintaining referral relationships.

``(2) Conditions.--With respect to an entity that proposes to provide early intervention services under paragraph (1), such

(B) in subsection (c)(2)(B), by striking ``homemaker or'';

(3) in section 2615(a) <<NOTE: 42 USC 300ff-25.>> by striking ``section 2612(a)(3)'' and inserting ``section 2612(b)(3)(F)''; and

(4) in section <<NOTE: 42 USC 300ff-26.>> 2616(a) by striking ``section 2612(a)(5)'' and inserting ``section 2612(b)(3)(B)''.

SEC. 202. AIDS DRUG ASSISTANCE PROGRAM.

(a) Requirement of Minimum Drug List.--Section 2616 of the Public Health Service Act (42 U.S.C. 300ff-26) is amended--

(1) in subsection (c), by striking paragraph (1) and inserting the following:

``(1) ensure that the therapeutics included on the list of classes of core antiretroviral therapeutics established by the Secretary under subsection (e) are, at a minimum, the treatments provided by the State pursuant to this section;'';

(2) by redesignating subsection (e) as subsection (f); and

(3) by inserting after subsection (d) the following:

``(e) List of Classes of Core Antiretroviral Therapeutics.--For purposes of subsection (c)(1), the Secretary shall develop and maintain a list of classes of core antiretroviral therapeutics, which list shall be based on the therapeutics included in the guidelines of the Secretary known as the Clinical Practice Guidelines for Use of HIV/AIDS Drugs, relating to drugs needed to manage symptoms associated with HIV. The preceding sentence does not affect the authority of the Secretary to modify such Guidelines.''.

(b) Drug Rebate Program.--Section 2616 of the Public Health Service Act, as amended by subsection (a)(2) of this section, is amended by adding at the end the following:

``(g) Drug Rebate Program.--A State shall ensure that any drug rebates received on drugs purchased from funds provided pursuant to this section are applied to activities supported under

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this subpart, with priority given to activities described under this section.''.

SEC. 203. DISTRIBUTION OF FUNDS.

(a) Distribution Based on Living Cases of HIV/AIDS.--

(1) State distribution factor.--Section 2618(a)(2) of the Public Health Service Act (42 U.S.C. 300ff-28(a)(2)) is amended--

(A) in subparagraph (B), by striking ``estimated number of living cases of acquired immune deficiency syndrome in the eligible area involved'' and inserting ``number of living cases of HIV/AIDS in the State involved''; and

(B) by amending subparagraph (D) to read as follows:

``(D) Living cases of hiv/aids.--

``(i) Requirement of names-based reporting.--Except as provided in clause (ii), the number determined under this subparagraph for a State for a fiscal year for purposes of subparagraph (B) is the number of living names-based cases of HIV/AIDS in the State that, as of December 31 of the most recent calendar year for which such data is available, have been reported to and confirmed by the Director of the Centers for Disease Control and Prevention.

``(ii) Transition period; exemption regarding

not names-based (referred to in this subparagraph as `code-based reporting'), the Secretary shall, for purposes of this subparagraph, modify the number of such cases reported for the State in order to adjust for duplicative reporting in and among systems that use code-based reporting.

``(II) Adjustment rate.--The adjustment rate under subclause (I) for a State shall be a reduction of 5 percent in the number of living non-AIDS cases of HIV reported for the State.

``(vii) List of states meeting standard regarding december 31, 2005.--

``(I) In general.--If a State is specified in subclause (II), the State shall be considered to meet the standard described in clause (ii)(I). No other State may be considered to meet such standard.

``(II) Relevant states.--For purposes of subclause (I), the States specified in this subclause are the following: Alaska, Alabama, Arkansas, Arizona, Colorado, Florida, Indiana, Iowa, Idaho, Kansas, Louisiana, Michigan, Minnesota, Missouri, Mississippi, North Carolina, North Dakota, Nebraska, New Jersey, New Mexico, New York, Nevada, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Wisconsin, West Virginia, Wyoming, Guam, and the Virgin Islands.

``(viii) Rules of construction regarding acceptance of reports.--

``(I) Cases of aids.--With respect to a State that is subject to the requirement under clause (i) and is not in compliance with the requirement for names-based reporting of living non-AIDS cases of HIV, the Secretary shall, notwithstanding such noncompliance, accept reports of living cases of AIDS that are in accordance with such clause.

``(II) Applicability of exemption requirements.--The provisions of clauses (ii) through (vii)

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may not be construed as having any legal effect for fiscal year 2010 or any subsequent fiscal year, and accordingly, the status of a State for purposes of such clauses may not be considered after fiscal year 2009.

``(ix) Program for detecting inaccurate or fraudulent counting.--The Secretary shall carry out a program to monitor the reporting of names-based cases for purposes of this subparagraph and to detect instances of inaccurate reporting, including fraudulent reporting.''.

(2) Non-ema distribution factor.--Section 2618(a)(2)(C) of the Public Health Service Act (42 U.S.C. 300ff-28(a)(2)(C)) is

``(E) Code-based states; limitation on increase in grant.--

``(i) In general.--

For <<NOTE: Applicability.>> each of the fiscal years 2007 through 2009, if code-based reporting (within the meaning of subparagraph (D)(vi)) applies in a State as of the beginning of the fiscal year involved, then notwithstanding any other provision of this paragraph, the amount of the grant pursuant to paragraph (1) for the State may not for the fiscal year involved exceed by more than 5 percent the amount of the grant pursuant to this paragraph for the State for the preceding fiscal year, except that the limitation under this clause may not result in a grant pursuant to paragraph (1) for a fiscal year that is less than the minimum amount that applies to the State under such paragraph for such fiscal year.

``(ii) Use of amounts involved.--For each of the fiscal years 2007 through 2009, amounts available as a result of the limitation under clause (i) shall be made available by the Secretary as additional amounts for grants pursuant to section 2620, subject to subparagraph (H).''; and

(4) by redesignating subparagraph (I) as subparagraph (F).

(c) Separate ADAP Grants.--Section 2618(a)(2)(G) of the Public Health Service Act (42 U.S.C. 300ff-28(a)(2)(G)), as redesignated by subsection (b)(4) of this section, is amended--

(1) in clause (i)--

(A) in the matter preceding subclause (I), by striking ``section 2677'' and inserting ``section 2623'';

(B) in subclause (II), by striking the period at the end and inserting a semicolon; and

(C) by adding after and below subclause (II) the following:

``which product shall then, as applicable, be increased under subparagraph (H).'';

(2) in clause (ii)--

(A) by striking subclauses (I) through (III) and inserting the following:

``(I) In general.--From amounts made available under subclause (V), the Secretary shall award supplemental grants to States described in subclause (II) to enable such States to purchase and distribute to eligible individuals under section 2616(b) pharmaceutical therapeutics described under subsections (c)(2) and (e) of such section.

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``(II) Eligible states.--For purposes of subclause (I), a State shall be an eligible State if the State did not have unobligated funds subject to reallocation under section 2618(d) in the previous fiscal year and, in accordance with criteria established by the Secretary, demonstrates a severe need for a grant under this clause. For purposes of determining severe need, the

apply with respect to each grant awarded under paragraph (1) and with respect to each grant awarded under subparagraph (G).

``(ii) Fiscal year 2007.--For purposes of clause (i) as applied for fiscal year 2007, the references in such clause to subparagraph (G) are deemed to be references to subparagraph (I) as such subparagraph was in effect for fiscal year 2006.

``(iii) Fiscal years 2008 and 2009.--For each of the fiscal years 2008 and 2009, the Secretary shall ensure that the total for a State of the grant pursuant to paragraph (1) and the grant pursuant to subparagraph (G) is not less than 100 percent of such total for the State for fiscal year 2007.

``(iv) Source of funds for increase.--

``(I) In general.--From the amount reserved under section 2623(b)(2) for a fiscal year, and from amounts available for such section pursuant to subsection (d) of this section, the Secretary shall make available such amounts as may be necessary to comply with clause (i).

``(II) Pro rata reduction.--If the amounts referred to in subclause (I) for a fiscal year are insufficient to fully comply with clause (i) for the year, the Secretary, in order to provide the additional funds necessary for such compliance, shall reduce on a pro rata basis the amount of each grant pursuant to paragraph (1) for the fiscal year, other than grants for States for which increases under clause (i) apply and other than States described in paragraph (1)(A)(i)(I). A reduction under the preceding sentence may not be made in an amount that would result in the State involved becoming eligible for such an increase.

``(v) Applicability.--This paragraph may not be construed as having any applicability after fiscal year 2009.''.

(e) Administrative Expenses; Clinical Quality Management.--Section 2618(b) of the Public Health Service Act (42 U.S.C. 300ff-28(b)) is amended--

(1) by redesignating paragraphs (2) through (7) as paragraphs (1) through (6);

(2) in paragraph (2) (as so redesignated)--

(A) by striking ``paragraph (5)'' and inserting ``paragraph (4)''; and

(B) by striking ``paragraph (6)'' and inserting ``paragraph (5)'';

(3) in paragraph (3) (as so redesignated)--

(A) by amending subparagraph (A) to read as follows:

``(A) In general.--Subject to paragraph (4), and except as provided in paragraph (5), a State may not use more than 10 percent of amounts received under a grant awarded under section 2611 for administration.'';

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(B) by redesignating subparagraphs (B) and (C) as

shall be made available by the Secretary for grants under section 2620, in addition to amounts made available for such grants under section 2623(b)(2).''.

(g) Definitions; Other Technical Amendments.--Section 2618(a) of the Public Health Service Act (42 U.S.C. 300ff-28(a)) is amended--

(1) in paragraph (1), in the matter preceding subparagraph (A), by striking ``section 2677'' and inserting ``section 2623'';

(2) in paragraph (1)(A)--

(A) in the matter preceding clause (i), by striking ``each of the several States and the District of Columbia'' and inserting ``each of the 50 States, the District of Columbia, Guam, and the Virgin Islands (referred to in this paragraph as a `covered State')''; and

(B) in clause (i)--

(i) in subclause (I), by striking ``State or District'' and inserting ``covered State''; and

(ii) in subclause (II)--

(I) by striking ``State or District'' and inserting ``covered State''; and

(II) by inserting ``and'' after the semicolon; and

(3) in paragraph (1)(B), by striking ``each territory of the United States, as defined in paragraph (3),'' and inserting ``each territory other than Guam and the Virgin Islands'';

(4) in paragraph (2)(C)(i), by striking ``or territory''; and

(5) by striking paragraph (3).

SEC. 204. ADDITIONAL AMENDMENTS TO SUBPART I OF PART B.

(a) References to Part B.--Subpart I of part B of title XXVI of the Public Health Service Act (42 U.S.C. 300ff-21 et seq.) is amended by striking ``this part'' each place such term appears and inserting ``section 2611''.

(b) Hepatitis.--Section 2614(a)(3) of the Public Health Service Act (42 U.S.C. 300ff-24(a)(3)) is amended by inserting ``, including specialty care and vaccinations for hepatitis co-infection,'' after ``health services''.

(c) Application for Grant.--

(1) Coordination.--Section 2617(b) of the Public Health Service Act (42 U.S.C. 300ff-27(b)) is amended--

(A) by redesignating paragraphs (4) through (6) as paragraphs (5) through (7), respectively;

(B) by inserting after paragraph (3), the following:

``(4) the designation of a lead State agency that shall--

``(A) administer all assistance received under this part;

``(B) conduct the needs assessment and prepare the State plan under paragraph (3);

``(C) prepare all applications for assistance under this part;

``(D) receive notices with respect to programs under this title;

``(E) <<NOTE: Deadline. Audits.>> every 2 years, collect and submit to the Secretary all audits, consistent with Office of Management and Budget circular A133, from grantees within the State, including audits regarding funds expended in accordance with this part; and

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``(F) carry out any other duties determined

section 2617(b).
``(2) An increasing need for HIV/AIDS-related services, including relative rates of increase in the number of cases of HIV/AIDS.
``(3) The relative rates of increase in the number of cases of HIV/AIDS within new or emerging subpopulations.
``(4) The current prevalence of HIV/AIDS.
``(5) Relevant factors related to the cost and complexity of delivering health care to individuals with HIV/AIDS in the eligible area.
``(6) The impact of co-morbid factors, including co-occurring conditions, determined relevant by the Secretary.
``(7) The prevalence of homelessness.
``(8) The prevalence of individuals described under section 2602(b)(2)(M).
``(9) The relevant factors that limit access to health care, including geographic variation, adequacy of health insurance coverage, and language barriers.
``(10) The impact of a decline in the amount received pursuant to section 2618 on services available to all individuals with HIV/AIDS identified and eligible under this title.

``(c) Priority in Making Grants.--The Secretary shall provide funds under this section to a State to address the decline in services related to the decline in the amounts received pursuant to section 2618 consistent with the grant award to the State for fiscal year 2006, to the extent that the factor under subsection (b)(10) (relating to a decline in funding) applies to the State.
``(d) Report on the Awarding of Supplemental Funds.--Not later than 45 days after the awarding of supplemental funds under this section, the Secretary shall submit to Congress a report concerning such funds. Such report shall include information detailing--
``(1) the total amount of supplemental funds available under this section for the year involved;
``(2) the amount of supplemental funds used in accordance with the hold harmless provisions of section 2618(a)(2);
``(3) the amount of supplemental funds disbursed pursuant to subsection (c);
``(4) the disbursement of the remainder of the supplemental funds after taking into account the uses described in paragraphs (2) and (3); and
``(5) the rationale used for the amount of funds disbursed as described under paragraphs (2), (3), and (4).

``(e) Core Medical Services.--The provisions of section 2612(b) apply with respect to a grant under this section to the same extent and in the same manner as such provisions apply with respect to a grant made pursuant to section 2618(a)(1).
``(f) Applicability of Grant Authority.--The authority to make grants under this section applies beginning with the first fiscal year for which amounts are made available for such grants under section 2623(b)(1).''.

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SEC. 206. EMERGING COMMUNITIES.

Section 2621 of the Public Health Service Act, as redesignated by section 205(1) of this Act, is amended--
(1) in the heading for the section, by striking ``supplemental grants'' and inserting ``emerging communities'';
(2) in subsection (b)--
(A) in paragraph (2), by striking ``and'' at the end;
(B) by redesignating paragraph (3) as paragraph (4);

in which the Secretary obtains the information necessary for determining that the balance is required under paragraph (1) to be canceled, except that the availability of the funds for such grants is subject to section 2618(a)(2)(H) as applied for such year.

``(c) Formula Grants; Cancellation of Unobligated Balance of Grant Award; Waiver Permitting Carryover.--

``(1) In general.--Effective for fiscal year 2007 and subsequent fiscal years, if a grant award made to a State for a fiscal year pursuant to section 2618(a)(1) or 2618(a)(2)(G)(i) has an unobligated balance as of the end of the grant year for the award, the Secretary shall cancel that unobligated balance of the award, and shall require the State to return any amounts from such balance that have been disbursed to the State, unless--

``(A) before the end of the grant year, the State submits to the Secretary a written application for a waiver of the cancellation, which application includes a description of the purposes for which the State intends to expend the funds involved; and

``(B) the Secretary approves the waiver.

``(2) Expenditure by end of carryover year.--With respect to a waiver under paragraph (1) that is approved for a balance that is unobligated as of the end of a grant year for an award:

``(A) The unobligated funds are available for expenditure by the State involved for the one-year period beginning upon the expiration of the grant year (referred to in this section as the `carryover year').

``(B) If the funds are not expended by the end of the carryover year, the Secretary shall cancel that unexpended balance of the award, and shall require the State to return any amounts from such balance that have been disbursed to the State.

``(3) Use of cancelled balances.--In the case of any balance of a grant award that is cancelled under paragraph (1) or (2)(B), the grant funds involved shall be made available by the Secretary as additional amounts for grants under section 2620 for the first fiscal year beginning after the fiscal year in which the Secretary obtains the information necessary for determining that the balance is required under such paragraph

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to be canceled, except that the availability of the funds for such grants is subject to section 2618(a)(2)(H) as applied for such year.

``(4) Corresponding reduction in future grant.--

``(A) In general.--In the case of a State for which a balance from a grant award made pursuant to section 2618(a)(1) or 2618(a)(2)(G)(i) is unobligated as of the end of the grant year for the award--

``(i) the Secretary shall reduce, by the same amount as such unobligated balance, the amount of the grant under such section for the first fiscal year beginning after the fiscal year in which the Secretary obtains the information necessary for determining that such balance was unobligated as of the end of the grant year (which requirement for a reduction applies without regard to whether a waiver under paragraph (1) has been approved with respect to such balance); and

``(ii) the grant funds involved in such reduction shall be made available by the Secretary as additional funds for grants under section 2620 for such first fiscal year, subject to section

States for the purposes described in subsection (c).
``(b) Description of Compliant States.--For purposes of subsection (a), the laws or regulations of a State are in accordance with this subsection if, under such laws or regulations (including programs carried out pursuant to the discretion of State officials), both of the policies described in paragraph (1) are in effect, or both of the policies described in paragraph (2) are in effect, as follows:
``(1)(A) Voluntary opt-out testing of pregnant women.
``(B) Universal testing of newborns.
``(2)(A) Voluntary opt-out testing of clients at sexually transmitted disease clinics.
``(B) Voluntary opt-out testing of clients at substance abuse treatment centers.

The Secretary shall periodically ensure that the applicable policies are being carried out and recertify compliance.
``(c) Use of Funds.--A State may use funds provided under subsection (a) for HIV/AIDS testing (including rapid testing), prevention counseling, treatment of newborns exposed to HIV/AIDS, treatment of mothers infected with HIV/AIDS, and costs associated with linking those diagnosed with HIV/AIDS to care and treatment for HIV/AIDS.
``(d) Application.--A State that is eligible for the grant under subsection (a) shall submit an application to the Secretary, in such form, in such manner, and containing such information as the Secretary may require.
``(e) Limitation on Amount of Grant.--A grant under subsection (a) to a State for a fiscal year may not be made in an amount exceeding $10,000,000.
``(f) Rule of Construction.--Nothing in this section shall be construed to pre-empt State laws regarding HIV/AIDS counseling and testing.
``(g) Definitions.--In this section:
``(1) The term `voluntary opt-out testing' means HIV/AIDS testing--
``(A) that is administered to an individual seeking other health care services; and
``(B) in which--

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``(i) pre-test counseling is not required but the individual is informed that the individual will receive an HIV/AIDS test and the individual may opt out of such testing; and
``(ii) for those individuals with a positive test result, post-test counseling (including referrals for care) is provided and confidentiality is protected.
``(2) The term `universal testing of newborns' means HIV/AIDS testing that is administered within 48 hours of delivery to--
``(A) all infants born in the State; or
``(B) all infants born in the State whose mother's HIV/AIDS status is unknown at the time of delivery.

``(h) Authorization of Appropriations.--Of the funds appropriated annually to the Centers for Disease Control and Prevention for HIV/AIDS prevention activities, $30,000,000 shall be made available for each of the fiscal years 2007 through 2009 for grants under subsection (a), of which $20,000,000 shall be made available for grants to States with the policies described in subsection (b)(1), and $10,000,000 shall be made available for grants to States with the policies described in subsection (b)(2). Funds provided under this section are available until expended.''.

SEC. 210. CERTAIN PARTNER NOTIFICATION PROGRAMS; AUTHORIZATION OF

individual with HIV/AIDS (including the co-occurring conditions of the individual) means the following services:

``(A) Outpatient and ambulatory health services.

``(B) AIDS Drug Assistance Program treatments under section 2616.

``(C) AIDS pharmaceutical assistance.

``(D) Oral health care.

``(E) Early intervention services described in subsection (e).

``(F) Health insurance premium and cost sharing assistance for low-income individuals in accordance with section 2615.

``(G) Home health care.

``(H) Medical nutrition therapy.

``(I) Hospice services.

``(J) Home and community-based health services as defined under section 2614(c).

``(K) Mental health services.

``(L) Substance abuse outpatient care.

``(M) Medical case management, including treatment adherence services.

``(d) Support Services.--

``(1) In general.--For purposes of this section, the term `support services' means services, subject to the approval of the Secretary, that are needed for individuals with HIV/AIDS to achieve their medical outcomes (such as respite care for persons caring for individuals with HIV/AIDS, outreach services, medical transportation, linguistic services, and referrals for health care and support services).

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``(2) Definition of medical outcomes.--In this section, the term `medical outcomes' means those outcomes affecting the HIV-related clinical status of an individual with HIV/AIDS.

``(e) Specification of Early Intervention Services.--

``(1) In general.--The early intervention services referred to in this section are--

``(A) counseling individuals with respect to HIV/AIDS in accordance with section 2662;

``(B) testing individuals with respect to HIV/AIDS, including tests to confirm the presence of the disease, tests to diagnose the extent of the deficiency in the immune system, and tests to provide information on appropriate therapeutic measures for preventing and treating the deterioration of the immune system and for preventing and treating conditions arising from HIV/AIDS;

``(C) referrals described in paragraph (2);

``(D) other clinical and diagnostic services regarding HIV/AIDS, and periodic medical evaluations of individuals with HIV/AIDS; and

``(E) providing the therapeutic measures described in subparagraph (B).

``(2) Referrals.--The services referred to in paragraph (1)(C) are referrals of individuals with HIV/AIDS to appropriate providers of health and support services, including, as appropriate--

``(A) to entities receiving amounts under part A or B for the provision of such services;

``(B) to biomedical research facilities of institutions of higher education that offer experimental treatment for such disease, or to community-based organizations or other entities that provide such

treatment centers;
``(D) rural health clinics;
``(E) health facilities operated by or pursuant to a contract with the Indian Health Service;
``(F) community-based organizations, clinics, hospitals and other health facilities that provide early intervention services to those persons infected with HIV/AIDS through intravenous drug use; or
``(G) nonprofit private entities that provide comprehensive primary care services to populations at risk of HIV/AIDS, including faith-based and community-based organizations.
``(2) Underserved populations.--Entities described in paragraph (1) shall serve underserved populations which may include minority populations and Native American populations, ex-offenders, individuals with comorbidities including hepatitis B or C, mental illness, or substance abuse, low-income populations, inner city populations, and rural populations.''.

(b) Preferences in Making Grants.--Section 2653 of the Public Health Service Act (42 U.S.C. 300ff-53) is amended--
(1) in subsection (b)(1)--
(A) in subparagraph (A), by striking ``acquired immune deficiency syndrome'' and inserting ``HIV/AIDS''; and
(B) in subparagraph (D), by inserting before the semicolon the following: ``and the number of cases of individuals co-infected with HIV/AIDS and hepatitis B or C''; and

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(2) in subsection (d)(2), by striking ``special consideration'' and inserting ``preference''.

(c) Planning and Development Grants.--Section 2654(c) of the Public Health Service Act (42 U.S.C. 300ff-54(c)) is amended--
(1) in paragraph (1)--
(A) in subparagraph (A), by striking ``HIV''; and
(B) in subparagraph (B), by striking ``HIV'' and inserting ``HIV/AIDS''; and
(2) in paragraph (3), by striking ``or underserved communities'' and inserting ``areas or to underserved populations''.

SEC. 303. AUTHORIZATION OF APPROPRIATIONS.

Section 2655 of the Public Health Service Act (42 U.S.C. 300ff-55) is amended by striking ``such sums'' and all that follows through ``2005'' and inserting ``, $218,600,000 for fiscal year 2007, $226,700,000 for fiscal year 2008, and $235,100,000 for fiscal year 2009''.

SEC. 304. CONFIDENTIALITY AND INFORMED CONSENT.

Section 2661 of the Public Health Service Act (42 U.S.C. 300ff-61) is amended to read as follows:

``SEC. 2661. CONFIDENTIALITY AND INFORMED CONSENT.

``(a) Confidentiality.--The Secretary may not make a grant under this part unless, in the case of any entity applying for a grant under section 2651, the entity agrees to ensure that information regarding the receipt of early intervention services pursuant to the grant is maintained confidentially in a manner not inconsistent with applicable law.

individual may have exposed to HIV/AIDS, hepatitis B, or hepatitis C; and

``(ii) that emphasizes it is the duty of infected individuals to disclose their infected status to their sexual partners and their partners in the sharing of hypodermic needles; that provides advice to infected individuals on the manner in which such disclosures can be made; and that emphasizes that it is the continuing duty of the individuals to avoid any behaviors that will expose others to HIV/AIDS, hepatitis B, or hepatitis C; and

``(D) on the availability of the services of public health authorities with respect to locating and counseling any individual described in subparagraph (C);

``(4) if diagnosed with chronic hepatitis B or hepatitis C co-infection, the potential of developing hepatitis-related liver disease and its impact on HIV/AIDS; and

``(5) information regarding the availability of hepatitis B vaccine.

``(c) Additional Requirements Regarding Appropriate Counseling.--The Secretary may not make a grant under this part unless the applicant for the grant agrees that, in counseling individuals with respect to HIV/AIDS, the applicant will ensure that the counseling is provided under conditions appropriate to the needs of the individuals.

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``(d) Counseling of Emergency Response Employees.--The Secretary may not make a grant under this part to a State unless the State agrees that, in counseling individuals with respect to HIV/AIDS, the State will ensure that, in the case of emergency response employees, the counseling is provided to such employees under conditions appropriate to the needs of the employees regarding the counseling.

``(e) Rule of Construction Regarding Counseling Without Testing.--Agreements made pursuant to this section may not be construed to prohibit any grantee under this part from expending the grant for the purpose of providing counseling services described in this section to an individual who does not undergo testing for HIV/AIDS as a result of the grantee or the individual determining that such testing of the individual is not appropriate.''.

SEC. 306. GENERAL PROVISIONS.

(a) Applicability of Certain Requirements.--Section 2663 of the Public Health Service Act (42 U.S.C. 300ff-63) is amended by striking ``will, without'' and all that follows through ``be carried'' and inserting ``with funds appropriated through this Act will be carried''.

(b) Additional Required Agreements.--Section 2664(a) of the Public Health Service Act (42 U.S.C. 300ff-64(a)) is amended--

(1) in paragraph (1)--

(A) in subparagraph (A), by striking ``and'' at the end;

(B) in subparagraph (B), by striking ``and'' at the end; and

(C) by adding at the end the following:

``(C) information regarding how the expected expenditures of the grant are related to the planning process for localities funded under part A (including the planning process described in section 2602) and for States funded under part B (including the planning process described in section 2617(b)); and

``(D) a specification of the expected expenditures and how those expenditures will improve overall client outcomes, as described in the State plan under section 2617(b);'';

AIDS for youth.

``(2) The applicant will participate in the statewide coordinated statement of need under part B (where it has been initiated by the public health agency responsible for administering grants under part B) and in revisions of such statement.

``(3) <<NOTE: Deadline. Audits.>> The applicant will every 2 years submit to the lead State agency under section 2617(b)(4) audits regarding funds expended in accordance with this title and shall include necessary client-level data to complete unmet need calculations and Statewide coordinated statements of need process.

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``(d) Administration; Application.--A grant may only be awarded to an entity under subsection (a) if an application for the grant is submitted to the Secretary and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this section. Such application shall include the following:

``(1) Information regarding how the expected expenditures of the grant are related to the planning process for localities funded under part A (including the planning process outlined in section 2602) and for States funded under part B (including the planning process outlined in section 2617(b)).

``(2) A specification of the expected expenditures and how those expenditures will improve overall patient outcomes, as outlined as part of the State plan (under section 2617(b)) or through additional outcome measures.

``(e) Annual Review of Programs; Evaluations.--

``(1) Review regarding access to and participation in programs.--With <<NOTE: Deadline.>> respect to a grant under subsection (a) for an entity for a fiscal year, the Secretary shall, not later than 180 days after the end of the fiscal year, provide for the conduct and completion of a review of the operation during the year of the program carried out under such subsection by the entity. The purpose of such review shall be the development of recommendations, as appropriate, for improvements in the following:

``(A) Procedures used by the entity to allocate opportunities and services under subsection (a) among patients of the entity who are women, infants, children, or youth.

``(B) Other procedures or policies of the entity regarding the participation of such individuals in such program.

``(2) Evaluations.----The <<NOTE: Contracts.>> Secretary shall, directly or through contracts with public and private entities, provide for evaluations of programs carried out pursuant to subsection (a).

``(f) Administrative Expenses.--

``(1) Limitation.--A grantee may not use more than 10 percent of amounts received under a grant awarded under this section for administrative expenses.

``(2) Clinical quality management program.--A grantee under this section shall implement a clinical quality management program to assess the extent to which HIV health services provided to patients under the grant are consistent with the most recent Public Health Service guidelines for the treatment of HIV/AIDS and related opportunistic infection, and as applicable, to develop strategies for ensuring that such services are consistent with the guidelines for improvement in the access to and quality of HIV health services.

``SEC. 2681. <<NOTE: 42 USC 300ff-81.>> COORDINATION.

``(a) Requirement.--The Secretary shall ensure that the Health Resources and Services Administration, the Centers for Disease Control and Prevention, the Substance Abuse and Mental Health Services Administration, and the Centers for Medicare & Medicaid

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Services coordinate the planning, funding, and implementation of Federal HIV programs (including all minority AIDS initiatives of the Public Health Service, including under section 2693) to enhance the continuity of care and prevention services for individuals with HIV/AIDS or those at risk of such disease. The Secretary shall consult with other Federal agencies, including the Department of Veterans Affairs, as needed and utilize planning information submitted to such agencies by the States and entities eligible for assistance under this title.

``(b) Report.--The Secretary shall biennially prepare and submit to the appropriate committees of the Congress a report concerning the coordination efforts at the Federal, State, and local levels described in this section, including a description of Federal barriers to HIV program integration and a strategy for eliminating such barriers and enhancing the continuity of care and prevention services for individuals with HIV/AIDS or those at risk of such disease.

``(c) Integration by State.--As a condition of receipt of funds under this title, a State shall provide assurances to the Secretary that health support services funded under this title will be integrated with other such services, that programs will be coordinated with other available programs (including Medicaid), and that the continuity of care and prevention services of individuals with HIV/AIDS is enhanced.

``(d) Integration by Local or Private Entities.--As a condition of receipt of funds under this title, a local government or private nonprofit entity shall provide assurances to the Secretary that services funded under this title will be integrated with other such services, that programs will be coordinated with other available programs (including Medicaid), and that the continuity of care and prevention services of individuals with HIV is enhanced.

``SEC. 2682. <<NOTE: 42 USC 300ff-82.>> AUDITS.

``(a) In General.--For <<NOTE: Effective date.>> fiscal year 2009, and each subsequent fiscal year, the Secretary may reduce the amounts of grants under this title to a State or political subdivision of a State for a fiscal year if, with respect to such grants for the second preceding fiscal year, the State or subdivision fails to prepare audits in accordance with the procedures of section 7502 of title 31, United States Code. The Secretary shall annually select representative samples of such audits, prepare summaries of the selected audits, and submit the summaries to the Congress.

``(b) Posting on the Internet.--All audits that the Secretary receives from the State lead agency under section 2617(b)(4) shall be posted, in their entirety, on the Internet website of the Health Resources and Services Administration.

``SEC. 2683. PUBLIC <<NOTE: 42 USC 300ff-83.>> HEALTH EMERGENCY.

``(a) In General.--In an emergency area and during an emergency period, the Secretary shall have the authority to waive such requirements of this title to improve the health and safety of those receiving care under this title and the general public, except that the Secretary may not expend more than 5 percent of the funds allocated under this title for sections 2620 and section 2603(b).

``(b) Emergency Area and Emergency Period.--In this section:

``(1) Emergency area.--The term `emergency area' means a geographic area in which there exists--

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``(b) Definition of Severity of Need Index.--In this section, the term `severity of need index' means the index of the relative needs of individuals within a State or area, as identified by a number of different factors, and is a factor or set of factors that is multiplied by the number of living HIV/AIDS cases in a State or area, providing different weights to those cases based on needs. Such factors or set of factors may be different for different components of the provisions under this title.

``(c) Requirements for Secretarial Submission.--When the Secretary submits to the appropriate committees of Congress the severity of need index under subsection (a), the Secretary shall provide the following:

``(1) Methodology for and rationale behind developing the severity of need index, including information related to the field testing of the severity of need index.

``(2) An independent contractor analysis of activities carried out under paragraph (1).

``(3) Information regarding the process by which the Secretary received community input regarding the application and development of the severity of need index.

``(d) Annual Reports.--If the Secretary fails to submit the severity of need index under subsection (a) in either of fiscal years 2007 or 2008, the Secretary shall prepare and submit to the appropriate committees of Congress a report for such fiscal year--

``(1) that updates progress toward having client level data;

``(2) that updates the progress toward having a severity of need index, including information related to the methodology and process for obtaining community input; and

``(3) that, as applicable, states whether the Secretary could develop a severity of need index before fiscal year 2009.

``SEC. 2688. <<NOTE: 42 USC 300ff-88.>> DEFINITIONS.

``For purposes of this title:

``(1) AIDS.--The term `AIDS' means acquired immune deficiency syndrome.

``(2) Co-occurring conditions.--The term `co-occurring conditions' means one or more adverse health conditions in an individual with HIV/AIDS, without regard to whether the individual has AIDS and without regard to whether the conditions arise from HIV.

``(3) Counseling.--The term `counseling' means such counseling provided by an individual trained to provide such counseling.

``(4) Family-centered care.--The term `family-centered care' means the system of services described in this title that is targeted specifically to the special needs of infants, children, women and families. Family-centered care shall be based on a partnership between parents, professionals, and the community designed to ensure an integrated, coordinated, culturally sensitive, and community-based continuum of care for children, women, and families with HIV/AIDS.

``(5) Families with hiv/aids.--The term `families with HIV/AIDS' means families in which one or more members have HIV/AIDS.

``(6) HIV.--The term `HIV' means infection with the human immunodeficiency virus.

``(7) HIV/AIDS.--

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``(A) In general.--The term `HIV/AIDS' means HIV, and includes AIDS and any condition arising from AIDS.

``(B) Counting of cases.--The term `living cases of HIV/AIDS', with respect to the counting of cases in a

to entities eligible for funding under parts A, B, C, and D based on--

``(1) whether the funding will promote obtaining client level data as it relates to the creation of a severity of need index, including funds to facilitate the purchase and enhance the utilization of qualified health information technology systems;

``(2) demonstrated ability to create and maintain a qualified health information technology system;

``(3) the potential replicability of the proposed activity in other similar localities or nationally;

``(4) the demonstrated reliability of the proposed qualified health information technology system across a variety of providers, geographic regions, and clients; and

``(5) the demonstrated ability to maintain a safe and secure qualified health information system; or

``(6) newly emerging needs of individuals receiving assistance under this title.

``(c) Coordination.--The Secretary may not make a grant under this section unless the applicant submits evidence that the proposed program is consistent with the statewide coordinated statement of need, and the applicant agrees to participate in the ongoing revision process of such statement of need.

``(d) Privacy Protection.--The Secretary may not make a grant under this section for the development of a qualified health information technology system unless the applicant provides assurances to the Secretary that the system will, at a minimum, comply with the privacy regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996.

``(e) Replication.--The Secretary shall make information concerning successful models or programs developed under this part available to grantees under this title for the purpose of coordination, replication, and integration. To facilitate efforts under this subsection, the Secretary may provide for peer-based technical assistance for grantees funded under this part.''.

SEC. 602. AIDS EDUCATION AND TRAINING CENTERS.

(a) Amendments Regarding Schools and Centers.--Section 2692(a)(2) of the Public Health Service Act (42 U.S.C. 300ff-111(a)(2)) is amended--

(1) in subparagraph (A)--

(A) by inserting ``and Native Americans'' after ``minority individuals''; and

(B) by striking ``and'' at the end;

(2) in subparagraph (B), by striking the period and inserting ``; and''; and

(3) by adding at the end the following:

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``(C) train or result in the training of health professionals and allied health professionals to provide treatment for hepatitis B or C co-infected individuals.''.

(b) Authorizations of Appropriations for Schools, Centers, and Dental Programs.--Section 2692(c) of the Public Health Service Act (42 U.S.C. 300ff-111(c)) is amended to read as follows:

``(c) Authorization of Appropriations.--

``(1) Schools; centers.--For the purpose of awarding grants under subsection (a), there is authorized to be appropriated $34,700,000 for each of the fiscal years 2007 through 2009.

``(2) Dental schools.--For the purpose of awarding grants under subsection (b), there is authorized to be appropriated $13,000,000 for each of the fiscal years 2007 through 2009.''.

reserve $18,500,000 for each of the fiscal years 2007 through 2009.

``(E) For increasing the training capacity of centers to expand the number of health care professionals with treatment expertise and knowledge about the most appropriate standards of HIV disease-related treatments and medical care for racial and ethnic minority adults, adolescents, and children with HIV disease, the Secretary shall, of the amount appropriated under subsection (a), reserve $8,500,000 for each of the fiscal years 2007 through 2009.

``(c) Consistency With Prior Program.--With respect to the purpose described in subsection (a), the Secretary shall carry out this section consistent with the activities carried out under this title by the Secretary pursuant to the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2002 (Public Law 107-116).''.

TITLE VII--MISCELLANEOUS PROVISIONS

SEC. 701. HEPATITIS; USE OF FUNDS.

Section 2667 of the Public Health Service Act (42 U.S.C. 300ff-67) is amended--

(1) in paragraph (2), by striking ``and'' at the end;

(2) in paragraph (3), by striking the period and inserting ``; and''; and

(3) by adding at the end the following:

``(4) shall provide information on the transmission and prevention of hepatitis A, B, and C, including education about the availability of hepatitis A and B vaccines and assisting patients in identifying vaccination sites.''.

SEC. 702. CERTAIN REFERENCES.

Title XXVI of the Public Health Service Act (42 U.S.C. 300ff et seq.) is amended--

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(1) by <<NOTE: 42 USC 300ff-11, 300ff-28.>> striking ``acquired immune deficiency syndrome'' each place such term appears, other than in section 2687(1) (as added by section 501 of this Act), and inserting ``AIDS'';

(2) by striking ``such syndrome'' and inserting ``AIDS''; and

(3) by <<NOTE: 42 USC 300ff-12 et seq.>> striking ``HIV disease'' each place such term appears and inserting ``HIV/AIDS''.

SEC. 703. <<NOTE: 42 USC 300ff-11 et seq.>> REPEAL.

Effective <<NOTE: Effective date.>> on October 1, 2009, title XXVI of the Public Health Service Act (42 U.S.C. 300ff et seq.) is repealed.

Approved December 19, 2006.

LEGISLATIVE HISTORY--H.R. 6143:

HOUSE REPORTS: No. 109-695 (Comm. on Energy and Commerce).
CONGRESSIONAL RECORD, Vol. 152 (2006):
Sept. 28, considered and passed House.
Dec. 6, considered and passed Senate, amended.
Dec. 8, House concurred in Senate amendment.

Exhibit C
Budget Summary
Ryan White CARE Act
Sierra Foothills AIDS Foundation
March 1, 2010 through February 28, 2011

	Maximum Allowed 3/1/10 through 02/28/2011
Personnel:	
Executive Director (.2 FTE)	$12,000.00
Case Manager: (1.0 FTE)	39,500.00
Bookkeeper: (.33 FTE)	11,700.00
Case Aid/Administrative Assistant: (.5 FTE)	13,500.00
Subtotal Personnel:	$76,700.00
Benefits:	19,175.00
Total Personnel Costs:	**$95,875.00**
Operating Expenses:	
Rent & Utilities	$12,800.00
Communications	5,100.00
Travel	3,175.00
Office Supplies	2,238.78
Postage & Photocopying	1,250.00
Insurance	1,050.00
Computer/Office Equipment & Maintenance	875.00
Staff Volunteer Training/Development	425.00
Audit Fee	2,200.00
Total Operating Costs	**$29,113.78**
Total Case Management Costs	**$124,988.78**
Client Financial Aid	
Ambulatory Medical Care	$5,279.09
Oral Health Care	4,323.64
Mental Health / Counseling	1,764.55
Transportation	3,540.91
Emergency Financial Assistance	9,752.73
Total Client Financial Aid	**$24,660.92**
TOTAL Sierra Foothills AIDS Foundation CARE Act Budget:	**$149,649.70**

Exhibit C
Budget Narrative
Ryan White CARE Act
Sierra Foothills AIDS Foundation
March 1, 2010 through February 28, 2011

Case Management Services (Includes both office-based and field-based services) **$124,988.78**

Office-Based Case Management: This sub-category applies to the delivery of Case Management services in a traditional office setting established as the contractor's regular place of business.

Field-Based Case Management: This sub-category applies to the delivery of Case Management services in non-traditional settings such as at the home of the client, at homeless shelters, or other where clients may be temporarily located.

Personnel:

Executive Director (.2 FTE) **$12,000.00**
Overall management of the CARE program, responsible for all operations of the program and supervision of all staff. In addition provides back up for case management services. Also serves as volunteer coordinator responsible for recruiting, training and supervision of all volunteers.

Case Manager: (1.0 FTE) **$39,500.00**
Provides comprehensive case management services including intake and assessment, development of service plan, service plan monitoring, information and referral and benefits counseling.

Bookkeeper: (.33 FTE) **$11,700.00**
Responsible for accounts payable and receivable, invoicing, payroll and data entry.

Case Aid/Administrative Assistant: (.5 FTE) **$13,500.00**
Responsible for non professional assistance in carrying out tasks of case management services, clerical support, data entry, reception.

Subtotal Personnel:	**$76,700.00**
Benefits: Calculated at 25% of Personnel	**$19,175.00**
Total Personnel Costs:	**$95,875.00**

Operating Expenses:

Rent & Utilities **$12,800.00**
Office space and utilities needed to provide for service and administrative needs.

Communications **$5,100.00**
Phone, Internet, Fax services needed to provide for service needs.

Travel **$3,175.00**
Mileage and related travel costs of providing services and as needed to meet administrative needs.

Budget Narrative, Cont.

Office Supplies Consumable supplies needed to provide for services and administrative needs	**$2,238.78**
Postage & Photocopying Postage and photocopying costs needed to provide for services and administrative needs	**$1,250.00**
Insurance Insurance required as per contract.	**$1,050.00**
Computer/Office Equipment & Maintenance Maintenance and replacement of equipment as needed to provide for services and administrative needs	**$875.00**
Staff Volunteer Training/Development Staff development and training costs as needed to maintain professional competency.	**$425.00**
Audit Fee Audit as required per contract.	**$2,200.00**
Total Operating Costs	**$29,113.78**
Ambulatory Care	**$5,279.09**

Services funded under this category include the provision of professional, diagnostic, and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist or nurse practitioner in an outpatient, community-based and/or office-based facility that is appropriately licensed to provide such services. These services include diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, documenting medical history, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, care of minor injuries, education and counseling on health and nutritional issues, minor surgery and assisting in surgery, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care. Primary Medical Care for the Treatment of HIV Infection includes provisions of care that is consistent with Public Health Service Guidelines. Such care must include access to antiretrovirals and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.

Emergency Financial Assistance **$9,752.73**

(Includes Food Vouchers, Other Critical Need and Medications)

Direct emergency financial assistance for food vouchers and provision of medications not covered by the AIDS Drug Assistance Program (ADAP) or any other payer source as prescribed by the primary care physician or psychiatrist of an HIV/AIDS client for conditions (HIV/AIDS, related or not) which negatively impact the client's health and well-being.

Budget Narrative, Cont.

Mental Health Services Services funded under this category include psychological and psychiatric treatment and counseling services, from an organization licensed or authorized within the State of California to provide mental health services by mental health professionals including psychiatrists, psychologists, social workers, and counselors.	**$1,764.55**
Oral Health Care Services funded under this category include diagnostic, prophylactic and therapeutic services rendered by dentists, dental hygienists, dental assistants and other appropriately licensed or certified professional practitioners.	**$4,323.64**
Transportation Conveyance services provided to a client in order to access health care or psychosocial support services. May be provided routinely or on an emergency basis via a voucher program, bus passes, volunteer-based transportation services.	**$3,540.91**
Total Services	**$24,660.92**
Total Budget for Sierra Foothills AIDS Foundation	**$149,649.70**

EXHIBIT D
Ryan White CARE Act
Sierra Foothills AIDS Foundation
Units of Service Summary
March 1, 2010 through February 28, 2011

SERVICE PRIORITY	Service Code	Units of Service Description	Estimated Quantity # of UDC	Estimated Quantity # of Units	Unit Cost	Total Funding Available
Ambulatory Medical Care						
	01008	Primary care visit w/HCP	24	4691.82	1 unit = 1 vendor paid dollar	$4,691.82
	01009	Specialty care visit w/HCP	109	109.09	1 unit = 1 vendor paid dollar	$109.09
	010010	Laboratory services	1	478.18	1 unit = 1 vendor paid dollar	$478.18
Case Management						
	14020	1 15 minute field based face to face encounter	34	2956.00	1 unit = a 15 minute encounter	$47,458.75
	14021	1 15 minute field based other encounter	85	4829.01	1 unit = a 15 minute encounter	$77,530.03
Oral Care						
	02002	1 dental care visit	2	4323.64	1 unit = 1 vendor paid dollar	$4,323.64
Mental Health/Counseling						
	03045	Adult individual-psychological	2	1764.55	1 unit = 1 vendor paid encounter	$1,764.55
Transportation						
	11025	Client/family transportation	42	3540.91	1 unit = 1 vendor paid dollar	$3,540.91
Other Critical Need						
	11029	Emergency Financial Assistance	48	9752.73	1 unit = 1 vendor paid dollar	$9,752.73
TOTAL EXPENDITURE						**$149,649.70**

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