***Submit completed worksheet to:***

*Siskiyou County Clerk, 311 Fourth St. Room 201, Yreka, CA 96097*

# **AGENDA WORKSHEET**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Regular** | | |  | | | |  | **Time Requested:** | | | | | | **N/A** | | | | | | **Meeting Date:** | | | | **3/21/2023** | | | | |
| ***OR*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Consent** | | | |  | | |  | | | | | | | | | | | | | | | | | | | | | |
| **Contact Person/Department:** | | | | | | | | | | | | | **Shelly Davis, Director / Health & Human Services Agency – Public Health Division** | | | | | | | | | | | **Phone:** | | **841-2140** | | |
| **Address:** | | | | | **810 S Main Street, Yreka CA 96097** | | | | | | | | | | | | | | | | | | | | | | | |
| **Person Appearing/Title:** | | | | | | | | | | **Shelly Davis / Director of Public Health Division** | | | | | | | | | | | | | | | | | | |
| **Subject/Summary of Issue:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Siskiyou County Health and Human Services Agency – Public Health Division is respectfully requesting permission to approve the California Department of Health Care Services (DHCS) Medi-Cal County Inmate Program (MCIP) Participation Agreement 23-MCIPSISKIYOU-47 and the Program Agreement for Administrative Services 23-30052, covering period July 1, 2023 through and including June 30, 2026.  The purpose of the agreements is to create budgetary savings for the County for the medical care provided to Medi-Cal eligible inmates for inpatient stays over 24 hours. These agreements make federal financial participation available for medical care provided to Medi-Cal eligible county inmates, allowing Medi-Cal providers to directly bill DHCS for MCIP services.  County shall be obligated to reimburse DHCS for MCIP services for the non-federal share of all MCIP services provided to eligible County inmates at Eight Hundred Twenty Seven Dollars and Fifty Six Cents ($827.56) for administration fees. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Financial Impact:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **NO** |  | *Describe why no financial impact:* | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **YES** |  | *Describe impact by indicating amount budgeted and funding source below* | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Amount: | | | | | | | RATE/  $827.56 | | | |  |  | | |  | | |  | | | | | | | | | | |
| Fund: | | | | | | | 2111 | | | |  | Description: | | | Inmate Health | | | Org.: | | | 401081 | | Description: | | | | Inmate Health | |
| Account: | | | | | | | 723000 | | | |  | Description: | | | Professional Services | | |  | | | | | | | | | | |
| Activity Code: | | | | | | |  | | | |  | Description: | | |  | | |  | | | | | | | | | | |
| Local Preference: YES  NO | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| For Contracts – *Explain how vendor was selected:* N/A | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Additional Information: | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Recommended Motion:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Recommend that the Board of Supervisors approve and authorize the Chair to sign the California Department of Health Care Services Medi-Cal County Inmate Program Participation Agreement 23-MCIPSISKIYOU-47, and the Program Agreement for Administrative Services 23-30052, for FY 2023 through FY 2026. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Reviewed as recommended by policy:** | | | | | | | | | | | | | | | |  | ***Special Requests*:** | | | | | | | | | | | |
| County Counsel | | | | | |  | | | | | | | | | |
| *Certified Minute Order(s)* | | | | | YES | | | *Quantity:* | | | 1 |
| Auditor | | | | | |  | | | | | | | | | |
|  | | |  | | | |
| Personnel | | | | | |  | | | | | | | | | | *Other:* | | Please return 2 original signed Participation Agreements and 2 original signed Administrative Services Agreements to Public Health, Attn: Angela Zambrano-Ford  Attention Angela Zambrano-Ford | | | | | | | | | |
| CAO | | | | | |  | | | | | | | | | |  | | | | | | | | | | | |

***NOTE: For consideration for placement on the agenda, the original agenda worksheet and backup material must be submitted directly to the Board Clerk (after reviewing signatures have been obtained) by 12:00 p.m. on the Wednesday prior to the Board Meeting.*** Revised 8/09/2021