Memorandum of Understanding

Between _____ and County of Sonoma

This Memorandum of Understanding ("MOU") is entered into by _____ ("MCP**"**) and County of Sonoma on behalf of its Department of Health Services, a local health department ("LHD"), effective as of execution date ("Effective Date"). MCP, and MCP's relevant Subcontractor and/or Downstream Subcontractor, and LHD may be referred to herein as a "Party" and collectively as "Parties."

WHEREAS, MCP is required under the Medi-Cal Managed Care Contract Exhibit A, Attachment III, to enter into this MOU, a binding and enforceable contractual agreement, to ensure that Medi-Cal beneficiaries enrolled, or eligible to enroll, in MCP ("Members") are able to access and/or receive services in a coordinated manner from MCP and LHD; and

WHEREAS, the Parties desire to ensure that Members receive services available through LHD direct service programs in a coordinated manner and to provide a process to continuously evaluate the quality of care coordination provided; and

WHEREAS, the Parties understand and agree that to the extent any data that is protected health information ("PHI") or personally identifiable information ("PII") exchanged in furtherance of this agreement originates from the California Department of Public Health ("CDPH") owned databases, LHD must comply with all applicable federal and State statutes and regulations and any underlying CDPH/LHD agreement terms and conditions that impose restrictions on access to, use of, and disclosure of that data.

In consideration of the mutual agreements and promises hereinafter, the Parties agree as follows:

1. Definitions. Capitalized terms have the meaning ascribed by MCP's Medi-Cal Managed Care Contract with the Department of Health Care Services ("DHCS"), unless otherwise defined herein. The Medi-Cal Managed Care Contract is available on the DHCS webpage at www.dhcs.ca.gov.

a. "MCP Responsible Person" means the person designated by MCP to oversee MCP coordination and communication with the LHD Responsible Person, facilitate quarterly meetings in accordance with Section 9 of and ensure MCP's compliance with this MOU as described in Section 4 of this MOU. It is recommended that this person be in a leadership position with decision-making authority and authority to effectuate improvements in MCP practices.

b. "MCP-LHD Liaison" means MCP's designated point of contact(s) responsible for acting as the liaison between MCP and LHD Program Liaison(s) as described in Section 4 of this MOU. The MCP-LHD Liaison(s) must ensure that the appropriate communication and care coordination are ongoing between the Parties,

facilitate quarterly meetings in accordance with Section 10 of this MOU, and must provide updates to the MCP Responsible Person and/or MCP compliance officer as appropriate.

c. "LHD Responsible Person" means the person designated by LHD to oversee coordination and communication with MCP, facilitate quarterly meetings in accordance with Section 10 of this MOU, and ensure LHD's compliance with this MOU as described in Section 5 of this MOU. It is recommended that this person be in a leadership position with decision-making authority and authority to effectuate improvements in LHD practices.

d. "LHD Program Liaison" means LHD's designated point of contact(s) responsible for acting as the liaison between MCP and LHD as described in Section 5 of this MOU. The LHD Program Liaison(s) should ensure the appropriate communication and care coordination are ongoing between the Parties, facilitate quarterly meetings in accordance with Section 9 of this MOU, and should provide updates to the LHD Responsible Person as appropriate.

2. Term. This MOU is in effect as of the Effective Date and shall automatically renew annually, unless written notice of non-renewal is given in accordance with Attachment F, Section 17.c. of this MOU or as amended in accordance with Attachment F, Section 17.f of this MOU.

3. Services Covered by This MOU. This MOU governs the coordination between LHD and MCP for the delivery of care and services for Members who reside in LHD's jurisdiction and may be eligible for services provided, made available, or arranged for by LHD. The Parties are subject to additional requirements for specific LHD programs and services that LHD provides, which are listed in the applicable program-specific exhibits ("Program Exhibits"), each labeled with the specific program or service.

4. MCP Obligations.

a. Provision of Covered Services. MCP is responsible for authorizing Medically Necessary Covered Services and coordinating care for Members provided by MCP's Network Providers and other providers of carve-out programs, services and benefits, such as dental benefits.

b. Oversight Responsibility. The Regional Director, MOU Implementation, the designated MCP Responsible Person, listed in Exhibit A of this MOU, is responsible for overseeing MCP's compliance with this MOU. The MCP Responsible Person must:

i. Meet at least quarterly with the LHD Responsible Person and LHD Program Liaisons, as required by Section 10 of this MOU;

ii. Report no less frequently than quarterly on MCP's compliance with the MOU to MCP's compliance officer who is responsible for MOU compliance oversight

reports as part of MCP's compliance program and must address any compliance deficiencies in accordance with MCP's compliance program policies;

iii. Ensure there is sufficient staff at MCP who support compliance with and management of this MOU;

iv. Ensure the appropriate level of MCP leadership (i.e., persons with decision-making authority) are involved in implementation and oversight of the MOU engagements and ensure the appropriate levels of leadership from LHD are invited to participate in the MOU engagements, as appropriate;

v. Ensure training and education regarding MOU provisions are conducted annually for MCP's employees responsible for carrying out activities under this MOU, and as applicable for Subcontractors, Downstream Subcontractors, and Network Providers; and

vi. Serve, or may designate a person at MCP to serve, as the MCP-LHD Liaison, the point of contact and liaison with LHD or LHD programs. The MCP-LHD Liaison is listed in Exhibit A of this MOU. MCP must notify LHD of any changes to the MCP-LHD Liaison in writing as soon as reasonably practical but no later than the date of change and must notify DHCS within five Working Days of the change.

c. Compliance by Subcontractors, Downstream Subcontractors, and Network Providers. MCP must require and ensure that its Subcontractors, Downstream Subcontractors, and Network Providers, as applicable, comply with all applicable provisions of this MOU.

5. LHD Obligations.

a. Provision of Services. LHD is responsible for services provided or made available by LHD.

b. Oversight Responsibility. The Public Health Division Director, the designated LHD Responsible Person, listed in Exhibit B of this MOU, is responsible for overseeing LHD's compliance with this MOU. It is recommended that this person be in a leadership capacity with decision-making authority on behalf of LHD. LHD must designate at least one person to serve as the designated LHD Program Liaison, the point of contact and liaison with MCP, for the programs relevant to this MOU. It is recommended that this person be in a leadership capacity at the program level. The LHD Program Liaison(s) is listed in Exhibit B of this MOU. LHD may designate a liaison(s) by program or service line. LHD must notify MCP of changes to the LHD Program Liaison(s) as soon as reasonably practical but no later than the date of change, except when such prior notification is not possible, in which case, notice should be provided within five Working Days of the change.

6. Training and Education.

a. To ensure compliance with this MOU, MCP must provide training and orientation for its employees who carry out responsibilities under this MOU and, as applicable, for MCP's Network Providers, Subcontractors, and Downstream Subcontractors who assist MCP with carrying out MCP's responsibilities under this MOU. The training must include information on MOU requirements, what services are provided or arranged for by each Party, and the policies and procedures outlined in this MOU. For persons or entities performing these responsibilities as of the Effective Date, MCP must provide this training within 60 Working Days of the Effective Date. Thereafter, MCP must provide this training prior to any such person or entity performing responsibilities under this MOU and to all such persons or entities at least annually thereafter. MCP must require its Subcontractors and Downstream Subcontractors to provide training on relevant MOU requirements and LHD programs and services to its Network Providers.

b. In accordance with health education standards required by the Medi-Cal Managed Care Contract, MCP must provide educational materials to Members and Network Providers related to accessing Covered Services, including for services provided by LHD.

c. MCP must provide LHD, Members, and Network Providers with training and/or educational materials on how MCP's Covered Services and carved-out services may be accessed, including during nonbusiness hours.

7. Referrals.

a. Referral Process. The Parties must work collaboratively to develop policies and procedures that ensure Members are referred to the appropriate LHD program.

i. The Parties must facilitate referrals to the relevant LHD program for Members who may potentially meet the criteria of the LHD program and must ensure the LHD program has procedures for accepting referrals from MCP or responding to referrals where LHD programs cannot accept additional Members. Where applicable, such decisions should be made through a patient-centered, shared decision-making process. LHD should facilitate MCP referrals to LHD services or programs by assisting MCP in identifying the appropriate LHD program and/or should provide referral assistance when it is required.

ii. MCP must refer Members to LHD for direct service programs as appropriate including, without limitation, those set forth in Section 13.

iii. LHD should refer Members to MCP for any Community Supports services or additional care management programs for which they may qualify, such as Enhanced Care Management ("ECM") or Complex Case Management ("CCM"). However, if LHD is an ECM Provider pursuant to a separate agreement between

MCP and LHD for ECM services, this MOU does not govern LHD's provision of ECM services.

iv. LHD should refer Members to MCP for Covered Services.

b. Closed Loop Referrals. By January 1, 2025, or date otherwise determined by DHCS, the Parties must develop a process to implement DHCS guidance regarding closed loop referrals to applicable Community Supports, ECM benefits, and/or community-based resources, as referenced in the CalAIM Population Health Management Policy Guide,[1] DHCS All-Plan Letter ("APL") 22-024 or any subsequent version of the APL, and as set forth by DHCS through an APL or other similar guidance. The Parties must work collaboratively to develop and implement a process to ensure that MCP and LHD comply with the applicable provisions of closed loop referrals guidance within 90 Working Days of issuance. The Parties must establish a system that tracks cross-system referrals and meets all requirements set forth by DHCS through an APL or other, similar guidance.

8. Care Coordination and Collaboration.

a. Care Coordination.

i. The Parties must adopt policies and procedures for coordinating Members' access to care and services that incorporate all the specific requirements set forth in this MOU, including those in the Program Exhibits.

ii. The Parties must discuss and address individual care coordination issues or barriers to care coordination efforts at least quarterly.

iii. MCP must have policies and procedures in place to maintain collaboration with LHD and to identify strategies to monitor and assess the effectiveness of this MOU.

9. Blood Lead Screening/Follow-up Testing and Lead Case Management.

a. Blood Lead Screening and Follow-up Testing.

i. MCP must cover and ensure the provision of blood lead screenings and Medically Necessary follow up testing as indicated for Members at ages one (1) and two (2) in accordance with Cal. Code Regs. tit. 17 Sections 37000 – 37100, the Medi-Cal Managed Care Contract, and APL 20-016, or any superseding APL.

[1] CalAIM Population Health Management Policy Guide available at: https://www.dhcs.ca.gov/CalAIM/Documents/2023-PHM-Policy-Guide.pdf

ii. MCP must coordinate with its Network Providers to determine whether eligible Members have received blood lead screening and/or any Medically Necessary follow-up blood lead testing. If eligible Members have not received blood lead screening or indicated follow-up testing, MCP must arrange for and ensure each eligible Member receives blood lead screening and any indicated follow-up blood lead testing.

iii. MCP must identify, at least quarterly, all Members under six years of age with no record of receiving a required blood lead screening and/or Medically Necessary follow-up blood lead tests in accordance with CDPH requirements[2] and must notify the Network Provider or other responsible provider of the requirement to screen and/or test Members in accordance with requirements set forth in the Medi-Cal Managed Care Contract.

iv. MCP must ensure that its Network Providers, including laboratories analyzing for blood lead, report instances of elevated blood lead levels as required by Cal. Health & Safety Code Section 124130.

v. To the extent LHD, in the administration of a program or service is made aware that the child enrolled in MCP has not had a blood lead screening and to the extent that LHD resources allow, LHD will notify MCP of the need for the child to be screened.

vi. If the Member refuses the blood lead screening test, MCP must comply with the requirements set forth in the Medi-Cal Managed Care Contract to ensure a statement of voluntary refusal by the Member (if an emancipated minor) or the parent(s) or guardian(s) of the Member is documented in the Member's Medical Record.

b. Case Management for Elevated Blood Lead Levels

i. Where case management for elevated blood lead levels is provided by the Childhood Lead Poisoning Prevention Branch ("CLPPB") and administered by Care Management Section staff at CDPH, MCP must coordinate directly with the CLPPB to address barriers to care coordination, case management, or other matters related to services for children with elevated blood lead levels.

ii. Where case management for elevated blood lead levels is provided by LHD as a contracted entity with the CDPH CLPPB, and to the extent LHD resources allow, MCP must coordinate with the LHD Program Liaison, as necessary and applicable, to address barriers to care coordination, case management, or other matters related to services for children with elevated blood lead levels.

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[2] For more information see CDPH Childhood Lead Poisoning Prevention Branch, *Standard of Care on Screening for Childhood Lead Poisoning*, available at: https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/CLPPB/Pages/screen_regs_3.aspx

10. Quarterly Meetings.

a. The Parties must meet as frequently as necessary to ensure proper oversight of this MOU, but not less frequently than quarterly in order to address care coordination, Quality Improvement ("QI") activities, QI outcomes, systemic and case-specific concerns, and communication with others within their organizations about such activities. These meetings may be conducted virtually.

i. Within 30 Working Days after each quarterly meeting, MCP must post on its website the date and time the quarterly meeting occurred and, as applicable, distribute to meeting participants a summary of any follow-up action items or changes to processes that are necessary to fulfill MCP's obligations under the Medi-Cal Managed Care Contract and this MOU.

ii. MCP must invite the LHD Responsible Person, LHD Program Liaison(s), and LHD executives, to participate in MCP quarterly meetings to ensure appropriate committee representation, including a local presence, and to discuss and address care coordination and MOU-related issues. Subcontractors and Downstream Subcontractors, as well as other LHD program staff should be permitted to participate in these meetings, as appropriate.

iii. MCP must report to DHCS updates from quarterly meetings in a manner and at a frequency specified by DHCS.

b. Local Representation. MCP, represented by the MCP-LHD Liaison, must participate, as appropriate, at meetings or engagements to which MCP is invited by LHD, such as local county meetings, local community forums, and LHD engagements, to collaborate with LHD in equity strategy and wellness and prevention activities.

11. Quality Improvement. The Parties must develop QI activities specifically for the oversight of the requirements of this MOU, including, without limitation any applicable performance measures and QI initiatives, including those to prevent duplication of services, as well as reports that track referrals, Member engagement, and service utilization. MCP must document these QI activities in policies and procedures.

12. Population Needs Assessment ("PNA"). MCP will meet the PNA requirements by demonstrating meaningful participation in LHD's Community Health Assessments and Community Health Improvement Plans processes in the service area(s) where MCP operates.[3] MCP must coordinate with LHD to develop a process to implement DHCS guidance regarding the PNA requirements once issued. MCP must work collaboratively with LHD to develop and implement a process to ensure that MCP and LHD comply with the applicable provisions of the PNA guidance within 90 days of issuance.

[3] CalAIM: Population Health Management Policy Guide (updated August 2023), available at: https://www.dhcs.ca.gov/CalAIM/Documents/2023-PHM-Policy-Guide-August-Update081723.pdf

13. Non-Contracted LHD Services. If LHD does not have a separate Network Provider Agreement with MCP and provides any of the following services as an out-of-network provider

a. sexually transmitted infection ("STI") screening, assessment, and/or treatment;

b. family planning services;

c. immunizations; and

d. HIV testing and counseling MCP must reimburse LHD for these services at no less than the Medi-Cal Fee-For-Service ("FFS") rate as required by the Medi-Cal Managed Care Contract and as described in Exhibit C of this MOU.

14. Data Sharing and Confidentiality. The Parties must implement policies and procedures to ensure that the minimum necessary Member information and data for accomplishing the goals of this MOU are exchanged timely, maintained securely and confidentially, and in compliance with the requirements set forth below. The Parties must share information in compliance with applicable law, which may include the Health Insurance Portability and Accountability Act and its implementing regulations, as amended ("HIPAA"), 42 Code of Federal Regulations Part 2, and other State and federal privacy laws.

a. Data Exchange. MCP must, and LHD is encouraged to, share the minimum necessary data and information to facilitate referrals and coordinate care under this MOU. The Parties must have policies and procedures for supporting the timely and frequent exchange of Member information and data, which may include Member demographic, behavioral, dental and physical health information, diagnoses, progress notes, assessments, medications prescribed, laboratory results, and known changes in condition that may adversely impact the Member's health and/or welfare and that are relevant to the services provided or arranged for by LHD; for ensuring the confidentiality of exchanged information and data; and, if necessary, for obtaining Member consent. The minimum necessary information and data elements to be shared as agreed upon by the Parties are set forth in Exhibit G of this MOU. The Parties must annually review and, if appropriate, update Exhibit G to facilitate sharing of information and data.

i. MCP must, and LHD is encouraged to, share information necessary to facilitate referrals as described in Section 7 and further set forth in the Program Exhibits. The data elements to be shared must be agreed upon jointly by the Parties, reviewed annually, and set forth in this MOU.

ii. Upon request, MCP must provide the immunization status of the Members to LHD pursuant to the Medi-Cal Managed Care Contract and as may be described in Exhibit G.

b. Interoperability. MCP must make available to Members their electronic health information held by MCP pursuant to 42 Code of Federal Regulation Section 438.10 and in accordance with APL 22-026. MCP must make available an application program interface that makes complete and accurate Network Provider directory information available through a public-facing digital endpoint on MCP's website pursuant to 42 Code of Federal Regulation Sections 438.242(b) and 438.10(h).

c. Breach Notification and Coordination.
The Parties shall ensure compliance with all applicable privacy and security provisions, including Welfare & Institutions Code §14100.2 and DHCS breach notification protocols.

15. Dispute Resolution.

a. The Parties must agree to dispute resolution procedures such that in the event of any dispute, difference of opinion regarding the Party responsible for service coverage arising out of or relating to this MOU, the Parties must attempt, in good faith, to promptly resolve the dispute mutually between themselves. MCP must, and LHD should, document the agreed-upon dispute resolution procedures in policies and procedures. Pending resolution of any such dispute, MCP and LHD must continue without delay to carry out all their responsibilities under this MOU, including providing Members with access to services under this MOU, unless this MOU is terminated. If the dispute cannot be resolved within 30 Working Days of initiating such dispute or such other period as may be mutually agreed to by the Parties in writing, either Party may pursue its available legal and equitable remedies under California law.

b. Disputes between MCP and LHD that cannot be resolved in a good faith attempt between the Parties must be forwarded by MCP to DHCS and may be forwarded by LHD to DHCS. Until the dispute is resolved, the Parties may agree to an arrangement satisfactory to both Parties regarding how the services under dispute will be provided.

c. Nothing in this MOU or provision constitutes a waiver of any of the government claim filing requirements set forth in Title I, Division 3.6, of the California Government Code or as otherwise set forth in local, State, or federal law.

16. Equal Treatment. Nothing in this MOU is intended to benefit or prioritize Members over persons served by LHD who are not Members. Pursuant to Title VI, 42 United States Code Section 2000d, et seq., LHD cannot provide any service, financial aid, or other benefit to an individual that is different, or is provided in a different manner, from that provided to others by LHD.

17. General.

a. MOU Posting. MCP must post this executed MOU on its website.

b. Documentation Requirements. MCP must retain all documents demonstrating compliance with this MOU for at least 10 years as required by the Medi-Cal Managed Care Contract. If DHCS requests a review of any existing MOU, MCP

must submit the requested MOU to DHCS within 10 Working Days of receipt of the request.

c. Notice. Any notice required or desired to be given pursuant to or in connection with this MOU must be given in writing, addressed to the noticed Party at the Notice Address set forth below the signature lines of this MOU. Notices must be (i) delivered in person to the Notice Address; (ii) delivered by messenger or overnight delivery service to the Notice Address; (iii) sent by regular United States mail, certified, return receipt requested, postage prepaid, to the Notice Address; or (iv) sent by email, with a copy sent by regular United States mail to the Notice Address. Notices given by in-person delivery, messenger, or overnight delivery service are deemed given upon actual delivery at the Notice Address. Notices given by email are deemed given the day following the day the email was sent. Notices given by regular United States mail, certified, return receipt requested, postage prepaid, are deemed given on the date of delivery indicated on the return receipt. The Parties may change their addresses for purposes of receiving notice hereunder by giving notice of such change to each other in the manner provided for herein.

d. Delegation. MCP may delegate its obligations under this MOU to a Fully Delegated Subcontractor or Partially Delegated Subcontractor as permitted under the Medi-Cal Managed Care Contract, provided that such Fully Delegated Subcontractor or Partially Delegated Subcontractor is made a Party to this MOU. Further, the Parties may enter into Subcontractor Agreements or Downstream Subcontractor Agreements that relate directly or indirectly to the performance of MCP's obligations under this MOU. Other than in these circumstances, MCP cannot delegate the obligations and duties contained in this MOU.

e. Annual Review. MCP must conduct an annual review of this MOU to determine whether any modifications, amendments, updates, or renewals of responsibilities and obligations outlined within are required. MCP must provide DHCS evidence of the annual review of this MOU as well as copies of any MOU modified or renewed as a result.

f. Amendment. This MOU may only be amended or modified by the Parties through a writing executed by the Parties. However, this MOU is deemed automatically amended or modified to incorporate any provisions amended or modified in the Medi-Cal Managed Care Contract, or as required by applicable law or any applicable guidance issued by a State or federal oversight entity.

g. Governance. This MOU is governed by and construed in accordance with the laws of the State of California.

h. Independent Contractors. No provision of this MOU is intended to create, nor is any provision deemed or construed to create any relationship between LHD and MCP other than that of independent entities contracting with each other hereunder solely for the purpose of effecting the provisions of this MOU. Neither LHD

nor MCP, nor any of their respective contractors, employees, agents, or representatives, is construed to be the contractor, employee, agent, or representative of the other.

i. Counterpart Execution. This MOU may be executed in counterparts, signed electronically and sent via PDF, each of which is deemed an original, but all of which, when taken together, constitute one and the same instrument.

j. Superseding MOU. This MOU constitutes the final and entire agreement between the Parties and supersedes any and all prior oral or written agreements, negotiations, or understandings between the Parties that conflict with the provisions set forth in this MOU. It is expressly understood and agreed that any prior written or oral agreement between the Parties pertaining to the subject matter herein is hereby terminated by mutual agreement of the Parties.

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The Parties represent that they have authority to enter into this MOU on behalf of their respective entities and have executed this MOU as of the Effective Date.

MCP CEO or Responsible Person

_____

Signature:
Date:
Name:
Title:

LHD Director or Responsible Person

Agency Director or Responsible Person

Signature:
Date:
Name:
Title:

Exhibits A and B

MCP-Agency Liaisons

Liaisons	
MCP Responsible Person	
MCP LHD Liaison	
MCP Agency Liaison	

Agency Liaisons

Liaisons	
Agency Responsible Person	
Agency Liaison	

Exhibit C. Non-Contracted LHD Services.

This Exhibit C governs LHD's provision of any of the services listed below only to the extent that such services are provided by LHD as a non-contracted Provider of MCP Covered Services. If LHD has a Network Provider Agreement with MCP pursuant to which any of these services are covered, such Network Provider Agreement governs.

a. Immunizations. MCP is responsible for providing all immunizations to Members recommended by the Centers for Disease Control and Prevention ("CDC") Advisory Committee on Immunization Practices ("ACIP") and Bright Futures/American Academy of Pediatrics ("AAP") pursuant to the Medi-Cal Managed Care Contract and must allow Members to access immunizations through LHD regardless of whether LHD is in MCP's provider network, and MCP must not require prior authorization for immunizations from LHD.

i. MCP must reimburse LHD for immunization services provided under this MOU at no less than the Medi-Cal FFS rate.

ii. MCP must reimburse LHD for the administration fee for immunizations given to Members who are not already immunized as of the date of immunization, in accordance with the terms set forth in APL 18-004.

b. Sexually Transmitted Infections ("STI") Services, Family Planning, and HIV Testing and Counseling. MCP must ensure Members have access to STI testing and treatment, family planning, and HIV testing and counseling services, including access through LHD pursuant to 42 United States Code Sections 1396a(a)(23) and 1396n(b) and 42 Code of Federal Regulations Section 431.51.

i. MCP must not require prior authorization or referral for Members to access STI, family planning or HIV testing services.

ii. MCP must reimburse LHD for STI services under this MOU at a rate no less than the Medi-Cal FFS rate for the diagnosis and treatment of an STI episode, as defined in Policy Letter No. 96-09.

iii. MCP must reimburse LHD for family planning services at a rate no less than the appropriate Medi-Cal FFS rate for services listed in Medi-Cal Managed Care Contract (Specific Requirements for Access to Program and Covered Services), provided to Members of childbearing age to temporarily or permanently prevent or delay pregnancy.

iv. If LHD provides HIV testing and counseling services to Members, MCP, in accordance with the Medi-Cal Managed Care Contract and federal law, including, but not limited to, 42 U.S.C. §§ 1396a(a)(23) and 1396n(b) and 42 Code of Federal Regulations Section 431.51, must reimburse LHD at a rate no less than the Medi-Cal FFS rate for such services as defined in PL § 96-09.

c. Reimbursement. MCP must reimburse the aforementioned STI testing and treatment, family planning, and HIV testing and counseling services only if LHD submits to MCP the appropriate billing information and either treatment records or documentation of a Member's refusal to release medical records to MCP.

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Exhibit D. Tuberculosis ("TB") Screening, Diagnosis, Treatment, and Care Coordination.

1. Parties' Obligations.

a. MCP must ensure access to care for latent tuberculosis infection ("LTBI") and active TB disease and coordination with LHD TB Control Programs for Members with active tuberculosis disease, as specified below.

b. MCP must arrange for and coordinate outpatient diagnostic and treatment services to all Members with suspected or active TB disease to minimize delays in initiating isolation and treatment of infectious patients. These outpatient services include physical examination, drug therapy, laboratory testing, and radiology.

c. MCP must consult with LHD to assess the risk of noncompliance with drug therapy for each Member who requires placement on anti-TB drug therapy, in accordance with the Medi-Cal Managed Care Contract.

2. Care Coordination.

a. **LTBI Testing and Treatment.**

i. TB Risk Assessment. MCP must provide screening through Network Providers for LTBI in all Members with risk factors for TB infection as recommended by the U.S. Preventive Services Task Force ("USPSTF") and the AAP.[4] The CDPH TB Risk Assessment Tools[5] should be used to identify adult and pediatric patients at risk for TB.

ii. TB Testing. MCP should encourage Network Providers to offer TB testing to Members who are identified with risk factors for TB infection and should recommend the Interferon Gamma Release Assay ("IGRA") blood test for Members when screening for LTBI in order to comply with current standards outlined by the CDC, CDPH, the California TB Controllers Association,[6] and/or the American Thoracic Society ("ATS")[7] for conducting TB screening.

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[4] AAP, Red Book Report of the Committee on Infectious Diseases, 32nd Ed., available at: https://publications.aap.org/redbook/book/347/chapter/5748923/Introduction

[5] CDPH, TB Risk Assessment Tools, available at: https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/TB-Risk-Assessment.aspx

[6] California Tuberculosis Controllers Association ("CTCA"), Latent Tuberculosis Infection Guidance for Preventing Tuberculosis in California, available at: https://ctca.org/guidelines/guidelines-latent-tuberculosis-infection-guideline/

[7] ATS/Infectious Diseases Society of America/CDC Clinical Practice Guidelines: Diagnosis of Tuberculosis in Adults and Children, available at: https://www.thoracic.org/statements/resources/tb-opi/diagnosis-of-tuberculosis-in-adults-and-children.PDF

iii. Other Diagnostic Testing and Treatment. MCP must arrange for and coordinate outpatient diagnostic and treatment services to all Members with LTBI. These outpatient services include physical examination, drug therapy, laboratory testing, and radiology.

iv. LTBI Treatment. MCP should instruct Network Providers to ensure Members have access to LTBI treatment in accordance with the updated 2023 USPSTF Recommendation[8] and CDC LTBI Treatment Guidelines[9], which recommend treating individuals diagnosed with LTBI.

b. **Reporting of Known or Suspected Active TB Cases.**

i. MCP must require Network Providers to report to LHD by electronic transmission, phone, fax, and/or the Confidential Morbidity Report[10] known or suspected cases of active TB disease for any Member residing within Sonoma County within one day of identification in accordance with Cal. Code Regs. tit. 17 Section 2500.

ii. MCP must obtain LHD's Health Officer (or designee's) approval in the jurisdiction where the hospital is located, prior to hospital discharge or transfer of any patients with known or suspected active TB disease.[11]

c. **Active TB Disease Testing and Treatment.**

i. MCP is encouraged to ensure Members are referred to specialists with TB experience (e.g., infectious disease specialist, pulmonologist) or to LHD's local TB clinic, when needed or applicable.

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[8] US Preventive Services Task Force, Screening for Latent Tuberculosis Infection in Adults (May 2, 2023): https://jamanetwork.com/journals/jama/fullarticle/2804319?utm_campaign=articlePDF&utm_medium=articlePDFlink&utm_source=articlePDF&utm_content=jama.2023.3954

[9] CTCA, Latent Tuberculosis Infection Guidance for Preventing Tuberculosis in California, available at: https://ctca.org/guidelines/guidelines-latent-tuberculosis-infection-guideline/.

[10] CDPH, TB Confidential Morbidity Report, available at: https://www.cdph.ca.gov/CDPH%20Document%20Library/ControlledForms/cdph110b.pdf.

[11] Cal. Health & Safety Code Sections 121365 and 121367 grant local health officers with the authority to issue any orders deemed necessary to protect the public health which may include authorizing the removal to, detention in, or admission into, a health facility or other treatment facility.

ii. Treatment Monitoring. MCP must provide Medically Necessary Covered Services to Members with TB, such as treatment monitoring, physical examinations, radiology, laboratory, and management of drug adverse events, including but not limited to the following:

1. Requiring Network Providers to obtain at least monthly sputum smears and cultures for acid-fast bacillus until there is a documented conversion to negative culture and referring patients unable to spontaneously produce sputum specimens to sputum induction or BAL, as needed.

2. Promptly submitting initial and updated treatment plans to LHD at least every three months until treatment is completed.

3. Reporting to LHD when the patient does not respond to treatment or misses an appointment.

4. Promptly reporting drug susceptibility results to LHD and ensuring access to rapid molecular identification and drug resistance testing during diagnosis and treatment as recommended by LHD.

iii. Treatment.

1. LHD and MCP must coordinate the provision of medication prescriptions for each Member to fill at an MCP-approved pharmacy.

2. LHD should coordinate the provision of TB treatment and related services, including for the provision of a treatment plan, with the Member's primary care physician ("PCP") or other assigned clinical services provider.

3. LHD and MCP will coordinate the inpatient admission of Members being treated by LHD for TB.

iv. Case Management.

1. LHD is encouraged to refer Members to MCP for ECM and Community Supports when LHD assesses the Member and identifies a need. MCP is encouraged to require its Network Providers to refer all Members with suspected or active TB disease, to the LHD Health Officer (or designee) for Directly Observed Therapy ("DOT") evaluation and services.

2. MCP must continue to provide all Medically Necessary Covered Services to Members with TB receiving DOT.

3. MCP must assess Members with the following conditions or characteristics for potential noncompliance and for consideration for DOT: substance users, persons with mental illness; the elderly, child, and adolescent Members; persons with unmet housing needs; persons with complex medical needs (e.g., end-stage renal disease, diabetes mellitus); and persons with language and/or cultural barriers. If a

Member's Network Provider believes that a Member with one or more of these risk factors is at risk for noncompliance, MCP must refer the Member to LHD for DOT.

4. LHD is responsible for assigning a TB case manager to notify the Member's PCP of suspected and active TB cases, and the TB case manager must be the primary LHD contact for coordination of care with the PCP or a TB specialist, whomever is managing the Member's treatment.

5. MCP should provide LHD with the contact information for the MCP-LHD Liaison to assist with coordination between the Network Provider and LHD for each diagnosed TB patient, as necessary.

6. LHD is responsible for assigning a TB case manager to notify the designated Network Provider of suspected and active cases, and the TB case manager must be the primary LHD contact for coordination of care with Network Providers.

d. **Case and Contact Investigations.**

i. As required by Cal. Health & Safety Code Sections 121362 and 121363, MCP must ensure that Network Providers share with LHD any testing, evaluation, and treatment information related to LHD's contact and/or outbreak investigations. The Parties must cooperate in conducting contact and outbreak investigations.

LHD is responsible for conducting contact investigation activities for all persons with suspected or confirmed active TB in accordance with Cal. Health & Safety Code Sections 121363 and 121365 and CDPH/CTCA contact investigations guidelines,[12] including:

1. Identifying and ensuring recommended testing, examination, and other follow-up investigation activities for contacts with suspected or confirmed active cases;

2. Communicating with MCP's Network Providers about guidance for examination of contacts and chemoprophylaxis; and

3. Working with Network Providers to ensure completion of TB evaluation and treatment.

iii. MCP is responsible for ensuring its Network Providers cooperate with LHD in the conduct of contact investigations,[13] including:

1. Providing medical records as requested and specified within the time frame requested;

2. Ensuring that its case management staff will be available to facilitate or coordinate investigation activities on behalf of MCP and its Network

Providers, including requiring its Network Providers to provide appropriate examination of Members identified by LHD as contacts within seven days;

3. Ensuring Member access to LTBI testing and treatment and following LTBI Treatment Guidelines published by the CDC.[14]

4. Requiring that its Network Providers to provide the examination results to LHD within one day for positive TB results, including:

(a) Results of IGRA or tuberculin tests conducted by Network Providers;

(b) Radiographic imaging or other diagnostic testing, if performed; and

(c) Assessment and diagnostic/treatment plans, following evaluation by the Network Provider.

3. Quality Assurance and Quality Improvement. MCP must consult regularly with LHD to develop outcome and process measures for care coordination as required by this Exhibit D for the purpose of measurable and reasonable quality assurance and improvement.

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[12] CDPH/CTCA Guidelines for the Assessment of Tuberculosis Patient Infectiousness and Placement into High and Lower Risk Settings, available at: https://ctca.org/wp-content/uploads/2018/11/ctcaciguidelines117_2.pdf; CDPH TB Control Branch, Resources for Local Health Departments, available at: https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/TB-Resources-for-LHDs.aspx

[13] Cal. Health & Safety Code Section 121350-121460 (standards for tuberculosis control).

[14] CDC, Latent Tuberculosis Infection Resources, available at: https://www.cdc.gov/tb/publications/ltbi/ltbiresources.htm

Exhibit E. Maternal Child and Adolescent Health.

This Exhibit E governs the coordination between LHD Maternal, Child and Adolescent Health Programs ("MCAH Programs") and MCP for the delivery of care and services to Members who reside in LHD's service area and may be eligible for one or more MCAH Program to the extent such programs are offered by LHD. These MCAH programs include, but are not limited to, the Black Infant Health Program, the Adolescent Family Life Program, the California Home Visiting Program, and/or the Children and Youth with Special Health Care Needs Program.

1. Parties' Obligations.

a. Per service coverage requirements under Medi-Cal for Kids and Teens, previously known as Early and Periodic Screening, Diagnostic, and Treatment ("EPSDT"),[15] MCP must ensure the provision of all screening, preventive, and Medically Necessary diagnostic and treatment services for Members under 21 years of age.

b. The MCP Responsible Person serves, or may designate a person at MCP to serve, as the day-to-day liaison with LHD specifically for MCAH Programs (e.g., the MCP-MCAH Liaison); the MCP-MCAH Liaison is listed in Exhibit A (the designated person may be the same as the MCP-LHD Liaison). MCP must notify LHD of any changes to the MCP-MCAH Liaison in accordance with Section 4 of this MOU.

c. To the extent that programs are offered by LHD and to the extent LHD resources allow, LHD must administer MCAH Programs, funded by CDPH, in accordance with CDPH guidance set forth in the Local MCAH Programs Policies and Procedures manual[16] and other guidance documents.

d. The LHD Responsible Person may also designate a person to serve as the day-to-day liaison with MCP specifically for one or more MCAH Programs (e.g., LHD Program Liaison(s)); the LHD Program Liaison(s) is listed in Exhibit B. LHD must notify MCP of changes to the LHD Program Liaison in accordance with Section 5 of this MOU.

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[15] Additional guidance available in APL 23-005:

https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-005.pdf

[16] CDPH, Local MCAH Programs Policies and Procedures (updated May 2023), available at: https://www.cdph.ca.gov/Programs/CFH/DMCAH/LocalMCAH/CDPH%20Document%20Library/ MCAH-Policies-and-Procedures.pdf

2. Referrals to, and Eligibility for and Enrollment in, MCAH Programs.

a. MCP must coordinate, as necessary, with the Network Provider, Member, and MCAH Program to ensure that the MCAH Program receives any necessary information or documentation to assist the MCAH Program with performing an eligibility assessment or enrolling a Member in an MCAH Program.

b. MCP must collaborate with LHD to update referral processes and policies designed to address barriers and concerns related to referrals to and from MCAH Programs.

c. LHD is responsible for providing MCP with information regarding how MCP and its Network Providers can refer to an MCAH Program, including, as applicable, referral forms, links, fax numbers, email addresses, and other means of making and sending referrals to MCAH Programs. LHD is responsible for working with MCP, as necessary, to revise referral processes and to address barriers and concerns related to referrals to MCAH Programs.[17]

d. LHD is responsible for the timely enrollment of, and follow-up with, Members eligible for MCAH Programs in accordance with MCAH Programs' enrollment practices and procedures and to the extent LHD resources allow. LHD must assess Member's eligibility for MCAH Programs within three (3) Working Days of receiving a referral.

e. LHD is responsible for coordinating with MCAH Programs to conduct the necessary screening and assessments to determine Members' eligibility for and the availability of one or more MCAH Programs and coordinate with MCP and/or its Network Providers as necessary to enroll Members.[18]

f. LHD MCAH Programs are not entitlement programs and may deny or delay enrollment if programs are at capacity.

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[17] CDPH, Local MCAH Programs Policies and Procedures, available at:

https://www.cdph.ca.gov/Programs/CFH/DMCAH/LocalMCAH/CDPH%20Document%20Library/ MCAH-Policies-and-Procedures.pdf

[18] CDPH, Local MCAH Programs Policies and Procedures, available at

https://www.cdph.ca.gov/Programs/CFH/DMCAH/LocalMCAH/CDPH%20Document%20Library/ MCAH-Policies-and-Procedures.pdf

3. Care Coordination and Collaboration.

a. MCP and LHD must coordinate to ensure Members receiving services through MCAH Programs have access to prevention and wellness information and services. LHD is encouraged to assist Members with accessing prevention and wellness services covered by MCP, by sharing resources and information to with Members about services for which they are eligible, to address needs identified by MCAH Programs' assessments.

b. MCP must screen Members for eligibility for care management programs such as CCM and ECM, and must, as needed, provide care management services for Members enrolled in MCAH Programs, including for comprehensive perinatal services, high-risk pregnancies, and children with special health care needs. MCP must engage LHD, as needed, for care management and care coordination.

c. MCP should collaborate with MCAH Programs on perinatal provider technical support and communication regarding perinatal issues and service delivery and to monitor the quality of care coordination.

4. Coordination of Medi-Cal for Kids and Teens (formerly EPSDT) Services.[19]

i. Where MCP and LHD have overlapping responsibilities to provide services to Members under 21 years of age, MCPs must do the following:

1. Assess the Member's need for Medically Necessary EPSDT services, including mental, behavioral, social, and/or developmental services, utilizing the AAP Periodicity Table[20] and the CDC's ACIP child vaccination schedule[21], the required needs assessment tools.

2. Determine what types of services (if any) are being provided by MCAH Programs, or other third-party programs or services.

3. Coordinate the provision of services with the MCAH Programs to ensure that MCP and LHD are not providing duplicative services and that the Member is receiving all Medically Necessary EPSDT services within 60 calendar days following the preventive screening or other visit identifying a need for treatment regardless of whether the services are Covered Services under the Medi-Cal Managed Care Contract.

5. Quarterly Meetings.

a. MCP must invite the LHD Responsible Person and LHD Program Liaison(s) for MCAH Programs to participate in MCP quarterly meetings as needed to ensure appropriate committee representation, including a local presence, and in order to discuss and address care

coordination and MOU-related issues. Other MCAH Program representatives may be permitted to participate in quarterly meetings.

b. MCP must participate, as appropriate, in meetings or engagements to which MCP is invited by LHD, such as local county meetings, local community forums, and county engagements, to collaborate with LHD for MCAH Programs on equity strategy and prevention activities.

6. Quality Improvement. MCP and LHD must ensure issues related to MCAH Program coordination and collaboration are included when addressing barriers to carrying out the obligations under this MOU.

7. Data Information and Exchange.

- MCP and LHD must exchange data and Member enrollment information in MCAH Programs and Member information related to prevention, wellness, and home visiting activities, or services designed to minimize health disparities, to ensure Members are receiving all Medically Necessary services.
- LHD will seek authorization from MCAH Program participants eligible to enroll in MCP services or programs such as ECM or Community Supports so LHD can provide MCP with participants' information regarding their needs for MCP Covered Services.]
- The Parties shall ensure compliance with all applicable privacy and security provisions, including Welfare & Institutions Code §14100.2 and DHCS breach notification protocols.

[19] Additional guidance available in APL 23-005:

https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-005.pdf

[20] AAP Periodicity Table available at:
https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf

[21] CDC ACIP Child Vaccination Schedule available at:
https://www.cdc.gov/vaccines/hcp/acip-recs/index.html

Exhibit F.

a. MCP and LHD must share the following data elements:

i. Member demographic information;

ii. Behavioral, dental, and physical health information;

iii. Diagnoses, progress notes, and assessments;

iv. Medications prescribed;

v. Laboratory results; and

vi. Known changes in condition that may adversely impact the Member's health and/or welfare and that are relevant to the services.

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Exhibit G. Women, Infants, and Children

This Memorandum of Understanding ("MOU") is entered into by _____ ("MCP") and Sonoma County Department of Health Services Women, Infants, and Children (WIC) ("Agency"), effective as of the date of execution ("Effective Date"). Agency, MCP, and MCP's relevant Subcontractors and/or Downstream Subcontractors are referred to herein as a "Party" and collectively as "Parties."

WHEREAS, MCP is required under the Medi-Cal Managed Care Contract, Exhibit A, Attachment III, to enter into this MOU, a binding and enforceable contractual agreement, to ensure that Medi-Cal beneficiaries enrolled, or eligible to enroll, in MCP ("Members") are able to access and/or receive services, including Medi-Cal for Kids and Teens (the Early and Periodic Screening, Diagnostic, and Treatment ("EPSDT") benefit) services, as well as other services that may not be covered by MCP, in a coordinated manner from MCP and Agency; and

WHEREAS, the Parties desire to ensure that Members receive services for which they may be eligible in a coordinated manner and to provide a process to continuously evaluate the quality of care coordination provided; and

WHEREAS, the Parties desire to work together to promote and support local, regional, and statewide efforts to provide food assistance, nutrition education and breastfeeding counseling, and access to health and social services to pregnant individuals, new parents and guardians, persons up to their first birthday (one year of age) ("Infants"), and persons over one year of age and up to their fifth birthday (five years of age) ("Children"); and

WHEREAS, the Parties understand and agree that to the extent that any data exchanged in furtherance of this MOU is protected health information ("PHI") or Personally Identifiable Information ("PII") derived from California Department of Public Health's ("CDPH") management information system for the Special Supplemental Nutrition Program for Women, Infants, and Children ("WIC" or "WIC Program") or otherwise collected, created, maintained, stored, transmitted, or used by Agency pursuant to its local agency agreement with CDPH, Agency must comply with all applicable federal and State statutes and regulations governing confidential information for the WIC Program and any underlying CDPH/WIC agreement terms and conditions that impose restrictions on the access, use, and disclosure of WIC data.

In consideration of the mutual agreements and promises hereinafter, the Parties agree as follows:

1. Definitions. Capitalized terms have the meaning ascribed by MCP's Medi-Cal Managed Care Contract with the California Department of Health Care Services ("DHCS") or 7 Code of Federal Regulations Section 246.2,

unless otherwise defined herein. The Medi-Cal Managed Care Contract is available on the DHCS webpage at www.dhcs.ca.gov.

a. "MCP Responsible Person" means the person designated by MCP to oversee MCP coordination and communication with the Agency Responsible Person, facilitate quarterly meetings in accordance with Section 9 of this MOU, and ensure MCP's compliance with this MOU as described in Section 4 of this MOU. It is recommended that this person be in a leadership position with decision-making authority and authority to effectuate improvements in MCP practices.

b. "MCP-Agency Liaison" means MCP's designated point of contact responsible for acting as the liaison between MCP and Agency as described in Section 4 of this MOU. The MCP-Agency Liaison must ensure the appropriate communication and care coordination are ongoing between the Parties, facilitate quarterly meetings in accordance with Section 9 of this MOU, and provide updates to the MCP Responsible Person and/or MCP compliance officer as appropriate.

c. "Agency Responsible Person" means the person designated by Agency to oversee coordination and communication with MCP and ensure Agency's compliance with this MOU as described in Section 5 of this MOU. It is recommended that this person be in a leadership position with decision-making authority and authority to effectuate improvements in Agency practices.

d. "Agency Liaison" means Agency's designated point of contact responsible for acting as the liaison between MCP and Agency as described in Section 5 of this MOU. The Agency Liaison should ensure the appropriate communication and care coordination are ongoing between the Parties, should facilitate quarterly meetings in accordance with Section 9 of this MOU, and should provide updates to the Agency Responsible Person as appropriate. It is recommended that the Agency Liaison have WIC Program subject matter expertise.

2. Term. This MOU is in effect as of the Effective Date and shall automatically renew annually, unless written notice of non-renewal is given in accordance with Attachment G, Section 14.c. of this MOU or as amended in accordance with Attachment G, Section 14.f of this MOU.

3. Services Covered by This MOU.

a. The WIC Program is authorized by Section 17 of the Child Nutrition Act of 1966, 42 United States Code Section 1786, and administered by CDPH. Agency is a public or private, nonprofit health or human service agency that, pursuant to a local agency agreement with CDPH, certifies applicant eligibility for the WIC Program and provides WIC Program benefits to participants.

b. Pursuant to the separate local agency agreement with CDPH, Agency provides WIC Program services to eligible persons in accordance with federal and State statutes and regulations governing the WIC Program ("WIC Services"). (42 United States Code Section 1786; 7 Code of Federal Regulations Section 246; Health and Safety Code Section 123275 et seq.; 22 California Code of Regulations Section 40601 et seq.) WIC Services include supplemental foods, nutrition education, and referrals to or information regarding other health-related or public assistance programs. (See 7 Code of Federal Regulations Sections 246.1, 246.7(b), 246.10, 246.11.)

c. Nothing in this MOU is intended to supersede, or conflict with, Agency's agreement with CDPH or CDPH's oversight authority over Agency's provision of WIC Services and the requirements applicable thereto. Should any conflict arise, the terms of Agency's agreement with CDPH will control.

d. This MOU governs coordination between Agency and MCP relating to the provision and delivery of MCP's Covered Services and WIC Services to Members.

e. As set forth in federal law, "WIC Participants" are Pregnant Women, women up to one year postpartum who are breastfeeding their Infants ("Breastfeeding Women"), women up to six months after termination of pregnancy ("Postpartum Women"), Infants, and Children who are receiving supplemental foods or food instruments, cash-value vouchers or electronic food benefits under the WIC Program, and the breastfed Infants of participant Breastfeeding Women. (7 Code of Federal Regulations Section 246.2 [defining participants as well as Pregnant Women, Postpartum Women, Breastfeeding Women, Infants, and Children for purposes of WIC Program participation].)

f. As set forth in federal law, "WIC Applicants" are Pregnant Women, Breastfeeding Women, Postpartum Women, Infants, and Children who are applying to receive WIC benefits, as well as the breastfed Infants of applicant Breastfeeding Women. (7 Code of Federal Regulations Section 246.2 [defining applicants].)

g. Agency provides referrals to or information regarding other health-related or public assistance programs to both WIC Applicants and WIC Participants. All other WIC Services are available exclusively to Members who are WIC Participants and the parents and guardians of Infant or Child participants in the case of nutrition education. The provision of WIC Services by Agency to Members must be limited to Members who are WIC Applicants, WIC Participants, or the parents or guardians thereof, as

applicable, and rendered in accordance with the statutes and regulations governing the WIC Program (see, e.g., 42 United States Code Section 1786(d); 7 Code of Federal Regulations Sections 246.2, 246.7) as well as the terms of Agency's local agency agreement with CDPH.

4. MCP Obligations.

a. Provision of Covered Services. MCP is responsible for authorizing Medically Necessary Covered Services and coordinating care for Members provided by MCP's Network Providers and other providers of carve-out programs, services, and benefits.

b. Oversight Responsibility. The Regional Director, MOU Implementation, the designated MCP Responsible Person listed in Exhibit A of this MOU, is responsible for overseeing MCP's compliance with this MOU. The MCP Responsible Person must:

i. Meet at least quarterly with Agency, as required by Section 9 of this MOU;

ii. Report on MCP's compliance with the MOU to MCP's compliance officer no less frequently than quarterly. MCP's compliance officer is responsible for MOU compliance oversight reports as part of MCP's compliance program and must address any compliance deficiencies in accordance with MCP's compliance program policies;

iii. Ensure there is sufficient staff at MCP to support compliance with and management of this MOU;

iv. Ensure the appropriate levels of MCP leadership (i.e., persons with decision-making authority) are involved in implementation and oversight of the MOU engagements and ensure the appropriate levels of leadership from Agency are invited to participate in the MOU engagements, as appropriate;

v. Ensure training and education regarding MOU provisions are conducted annually for MCP's employees responsible for carrying out activities under this MOU, and as applicable for Subcontractors, Downstream Subcontractors, and Network Providers; and

vi. Serve, or may designate a person at MCP to serve, as the MCP-Agency Liaison, the point of contact and liaison with Agency. The MCP-Agency Liaison is listed in Exhibit A of this MOU. MCP must notify Agency of any changes to the MCP-Agency Liaison in writing as soon as reasonably practical but no later than the date of change and must notify DHCS within five Working Days of the change.

c. Compliance by Subcontractors, Downstream Subcontractors, and Network Providers. MCP must require and ensure that its Subcontractors, Downstream Subcontractors, and Network Providers, as applicable, comply with all applicable provisions of this MOU.

5. Agency Obligations.

a. Provision of Covered Services. Agency is responsible for services provided or made available by Agency.

b. Oversight Responsibility. The designated Agency Responsible Person, listed in Exhibit B of this MOU, is responsible for overseeing Agency's compliance with this MOU. The Agency Responsible Person serves, or may designate a person to serve, as the designated Agency Liaison, the point of contact and liaison with MCP. The Agency Liaison is listed in Exhibit B of this MOU. Agency must notify MCP of any changes to the Agency Liaison in writing as soon as reasonably practical but no later than the date of change, except when such prior notification is not possible, in which case notice must be provided within five Working Days of the change.

6. Training and Education.

a. To ensure compliance with this MOU, MCP must provide training and orientation for its employees who carry out responsibilities under this MOU and, as applicable, for MCP's Network Providers, Subcontractors, and Downstream Subcontractors who assist MCP with carrying out MCP's responsibilities under this MOU. The training must include information on MOU requirements, what services are provided or arranged for by each Party, and the policies and procedures outlined in this MOU. For persons or entities performing these responsibilities as of the Effective Date, MCP must provide this training within 60 Working Days. of the Effective Date. Thereafter, MCP must provide this training prior to any such person or entity performing responsibilities under this MOU and to all such persons or entities at least annually thereafter. MCP must require its Subcontractors and Downstream Subcontractors to provide training on relevant MOU requirements and WIC Services to its Network Providers.

b. In accordance with health education standards required by the Medi-Cal Managed Care Contract, MCP must provide Members and Network Providers with educational materials related to accessing Covered Services and WIC Services provided by Agency, including:

i. Information about WIC Services, including who is eligible for WIC Services; how WIC Services can be accessed; WIC Program referral processes, including referral forms, links, fax numbers, email addresses, and other means of making and sending WIC Program referrals; referral processes for medical formula and nutritionals ; and care coordination approaches; and

ii. Information on nutrition and lactation topics, food insecurity screening, and cultural awareness.

c. MCP must provide Agency, Members, and Network Providers with training and/or educational materials, which may include the MCP provider manual, on how MCP's Covered Services and any carved-out services may be accessed, including during nonbusiness hours, and

information on MCP's relevant Covered Services and benefits such as doula services; lactation consultation services and other breastfeeding support services, including breast pump availability, related supplies, and issuance; outpatient services; Community Health Worker services, dyadic services; and related referral processes for such services.[1]

7. Referrals.

a. Referral Process. The Parties must work collaboratively to develop policies and procedures that ensure WIC-eligible Members are referred to the appropriate WIC Services and MCP's Covered Services. Referrals made pursuant to this MOU and any policies and procedures related thereto must comply with Section 13 of this MOU.

i. The Parties must facilitate referrals to Agency for Members who may meet the eligibility criteria for WIC Services.

ii. MCP must refer Members using a patient-centered, shared decision-making process.

iii. MCP must refer and document the referral to Agency of Members who are Pregnant Women, Breastfeeding Women, Postpartum Women, or the legal guardians of Members who are Infants or Children, including referrals made as part of the initial evaluation of newly pregnant individuals, pursuant to 42 Code of Federal Regulations Section 431.635(c) and any relevant DHCS guidance. MCP must have policies and procedures to identify and refer, and to ensure its Network Providers identify and refer, to Agency those Members who may be eligible for WIC Services.

1. As part of the referral, or as soon as possible thereafter, MCP must assist the Network Provider, Member, and Agency, as necessary, with sharing the Member's name, address, relevant portions of the medical record, Medi-Cal number, and contact information (such as the Member's phone/email) as well as a copy of the Member's current (within the past 12 months) hemoglobin and hematocrit laboratory values with Agency as soon as possible. If the Member has not yet had these laboratory tests, MCP must coordinate with the Network Provider and Member to assist the Member with obtaining such laboratory tests as soon as possible.

[1] Additional guidance is available at All-Plan Letter ("APL") 22-016, APL 22-031, and APL 22-029.

2. MCP must ensure its Network Providers share with Agency relevant information from patient visits, including, without limitation, height and weight measurements, hemoglobin/hematocrit values, blood lead values, immunization records for Infants and Children, and health conditions when referring their patients to Agency and/or when requested by Agency.

MCP must also ensure that its Network Providers share with Agency all WIC Program documentation, including necessary CDPH WIC Program forms.

iv. MCP must collaborate with Agency to update referral processes and policies designed to address barriers and concerns related to referrals and delays in service delivery.

v. Agency should refer Members to MCP for MCP's Covered Services, including any Community Supports services or care management programs for which Members may qualify, such as Enhanced Care Management ("ECM") or Complex Case Management. However, if Agency is also a Community Supports Provider or an ECM Provider pursuant to a separate agreement between MCP and Agency for Community Supports or ECM services, this MOU does not govern Agency's provision of Community Supports or ECM services.

vi. Upon notification from MCP that a Member may be eligible for WIC Services, and in accordance with its normal practices and procedures governing WIC application and certification, Agency must conduct the applicable screening and assessments to determine whether the Member is eligible for WIC Services.

vii. Agency must provide MCP with information about WIC referral process(es), including referral forms, links, fax numbers, email addresses, and other means of making and sending referrals to Agency. Agency must work with MCP, as necessary, to revise referral processes and address barriers and concerns related to referrals.

viii. Agency is responsible for the timely enrollment of, and follow-up with, Members eligible for WIC Services in accordance with the processing standards set forth in 7 Code of Federal Regulations Section 246.7(f) and California Code of Regulations, Title 22, Section 40675.

ix. As Agency is the payor of last resort, MCP and Agency must coordinate to ensure MCP understands Agency's processes and procedures for providing Members with medical formula and nutritionals as appropriate. MCP must ensure its Network Providers are informed of and follow the requirements for assisting Members in obtaining medical formula and nutritionals from Agency as appropriate. The following information must be included with the WIC referral after submitting a prior authorization (PA) to Medi-Cal Rx for provision of medical formula and nutritionals , including submission of the following information with the referral: (1) a copy of the Medi-Cal Rx PA denial notification upon receipt from Medi-Cal Rx or an attestation from the Provider that the request has been submitted to and denied by Medi-Cal Rx, and (2) a completed WIC Medical Formula and Nutritionals Request Form or a prescription or hospital discharge papers that contain: the WIC Participant's first and last name, date of birth a qualifying medical diagnosis, the name of the medical formula and nutritionals or medical nutritional, amount

required per day, length of time prescribed in months, WIC authorized food restrictions (if applicable), the Network Provider's signature or signature stamp, contact information of the Network Provider who wrote the medical documentation, and the date the Network Provider signed the medical documentation.

Closed Loop Referrals. To the extent that the following does not (a) require modifications to the WIC Program's management information system by CDPH or its contractors, (b) require Agency to store confidential WIC Participant or WIC Applicant information as defined in 7 Code of Federal Regulations Section 246.26(d)(1)(i) in any database or management information system other than the one in use by CDPH, or (c) otherwise conflict with current or future statutes, regulations, or guidance for the WIC Program, by January 1, 2025, or date otherwise determined by DHCS, the Parties must develop a process to implement DHCS guidance regarding closed loop referrals to applicable Community Supports, ECM benefits, and/or community-based resources, as referenced in the CalAIM Population Health Management Policy Guide,[2] DHCS APL 22-024, or any subsequent version of the APL, and as set forth by DHCS through an APL or other, similar guidance. Agency may include an individual WIC Applicant's or WIC Participant's information in a closed loop referral system only if the WIC Applicant, WIC Participant, or parent or guardian of a WIC Applicant or WIC Participant who is an Infant or Child signs a release authorizing the disclosure that complies with the requirements in 7 Code of Federal Regulations Section 246.26(d)(4) and federal guidance. The Parties must work collaboratively to develop and implement a process to ensure that MCP and Agency comply with the applicable provisions of closed loop referrals guidance within 90 Working Days of issuance of this guidance. The Parties must establish a system that tracks cross-system referrals and meets all requirements as set forth by DHCS through an APL or other, similar guidance.

[2] CalAIM Population Health Management Policy Guide, available at https://www.dhcs.ca.gov/CalAIM/Documents/2023-PHM-Policy-Guide.pdf

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8. Care Coordination and Collaboration.

a. Care Coordination.

i. The Parties must adopt policies and procedures for coordinating Members' access to care and services that incorporate all the requirements set forth in this MOU.

ii. The Parties must discuss and address individual barriers Members face in accessing MCP's Covered Services and/or WIC Services at least quarterly.

iii. MCP must have policies and procedures in place to maintain collaboration with Agency and to identify strategies to monitor and assess the effectiveness of this MOU.

b. Population Health Management. In order for MCP to ensure Members have access to Medi-Cal for Kids and Teens benefits and perinatal services, MCP must coordinate with Agency as necessary. MCP must undertake such activities in accordance with the Medi-Cal Managed Care Contract, DHCS Population Health Management Program, and policy guidance,[3] with a focus on high-risk populations such as Infants and Children with special needs and perinatal African Americans, Alaska Natives, and Pacific Islanders.

c. Maternity and Pediatric Care Coordination. MCP must implement processes to coordinate WIC Participant care between Agency and Network Providers in primary care; in obstetrics-gynecology; in pediatric care settings, with Network Providers and hospitals where WIC Participants deliver; and for WIC Participants transitioning from inpatient deliveries to outpatient postpartum and pediatric care settings. Agency is prohibited from charging costs associated with performing these activities to the WIC Program except to the extent that the costs are permissible under applicable federal authorities and the terms and conditions of Agency's local agreement with CDPH.

i. MCP must provide care management services for Members who are WIC Participants, as needed, including for high-risk pregnancies and Infants and Children with special needs, and engage Agency, as needed, in care management and care coordination.

[3] Ibid.

ii. MCP must ensure that its Network Providers arrange for the lactation services, or any relevant services outlined in applicable DHCS policy letters, and all lactation support requirements outlined in the Medi-Cal Managed Care Contract and Policy Letter 98-010, which includes

breastfeeding promotion and counseling services as well as the provision of breast pumps and donor human milk for fragile Infants.

iii. Agency may advise MCP when WIC Participants who are Members need lactation support services. MCP must arrange for breastfeeding peer counseling services.

iv. MCP must assist Members, as necessary, with the referral process and relevant follow-up to ensure Members obtain medical formula and nutritionals from the appropriate source in a timely manner.

9. Quarterly Meetings.

a. The Parties must meet as frequently as necessary to ensure proper oversight of this MOU, but not less frequently than quarterly, in order to address care coordination, Quality Improvement ("QI") activities, QI outcomes, systemic and case-specific concerns such as barriers or issues related to referrals for medical formula and nutritionals, and communication with others within their organizations about such activities. These meetings may be conducted virtually.

i. Within 30 Working Days after each quarterly meeting, MCP must post on its website the date and time the quarterly meeting occurred and, as applicable, distribute to meeting participants a summary of any follow-up action items or changes to processes that are necessary to fulfill MCP's obligations under the Medi-Cal Managed Care Contract and this MOU.

ii. MCP must invite the Agency Responsible Person, Agency Liaison, and Agency executives to participate in MCP quarterly meetings to ensure appropriate committee representation, including a local presence, and to discuss and address care coordination and MOU-related issues. Subcontractors and Downstream Subcontractors should be permitted to participate in these meetings, as appropriate.

iii. MCP must report to DHCS updates from quarterly meetings in a manner and at a frequency specified by DHCS.

b. Local Representation. MCP must participate, as appropriate, in meetings or engagements to which MCP is invited by Agency, such as local county meetings, local community forums, and Agency engagements, to collaborate with Agency in equity strategy and wellness and prevention activities.

10. Quality Improvement. The Parties must develop QI activities specifically for the oversight of the requirements of this MOU, including, without limitation, any applicable performance measures and QI initiatives, including those to prevent duplication of services, as well as reports that track referrals, Member engagement, and service utilization. MCP must document these QI activities in its policies and procedures.

11. Data Sharing and Confidentiality. The Parties must implement policies and procedures to ensure that the minimum necessary Member information and data for accomplishing the goals of this MOU are exchanged timely and maintained securely and confidentially and in compliance with the requirements set forth below. The Parties must share information in compliance with applicable law, which may include the Health Insurance Portability and Accountability Act and its implementing regulations, as amended ("HIPAA"), 42 Code of Federal Regulations Part 2, and other State and federal privacy laws, including but not limited to federal law governing the access, use, and disclosure of WIC Program information. Under federal law, confidential WIC Applicant and WIC Participant information is any information about a WIC Applicant or WIC Participant, whether it is obtained from the WIC Applicant, WIC Participant, or another source, or generated as a result of a WIC application or WIC certification or participation, that individually identifies a WIC Applicant or WIC Participant and/or family member(s). WIC Applicant or WIC Participant information is confidential, regardless of the original source and exclusive of previously applicable confidentiality provided in accordance with other federal, State, or local law. (7 Code of Federal Regulations Section 246.26(d)(1)(i).) Agency's sharing of confidential WIC Applicant and WIC Participant information with MCP must comply with 7 Code of Federal Regulations Section 246.26. Confidential WIC Applicant and WIC Participant information shall not be disclosed to MCP without obtaining explicit written consent meeting the requirements of 7 CFR § 246.26(d)(4), unless otherwise expressly permitted under federal WIC regulations.

a. Data Exchange. MCP must share the minimum necessary data and information to facilitate referrals and coordinate care under this MOU. Agency is encouraged to share the necessary minimum information and data to facilitate referrals and coordinate care under this MOU. Agency must secure appropriate written consent from WIC Participants and WIC Applicants on a form approved by CDPH before exchanging confidential WIC Participant and WIC Applicant information with MCP, and any exchange must comply with the requirements set forth in 7 Code of Federal Regulations Section 246.26(d)(4). The Parties must have policies and procedures for supporting the timely and frequent exchange of Member information and data, which may include behavioral health and physical health data; for ensuring the confidentiality of exchanged information and data; and, if necessary, for obtaining Member consent. The minimum necessary information and data elements are to be shared as agreed upon by the Parties as set forth in Exhibit H of this MOU, contingent on the receipt of Members' appropriate written consent. The Parties must annually review and, if appropriate, update Exhibit H of this MOU to facilitate sharing of information and data.

b. The Parties must enact policies and procedures to implement the following requirements with regard to information sharing:

i. The Parties must collaborate to implement data linkages to

streamline the referral process from MCP or its Network Providers to Agency to reduce the administrative burden on Agency and to increase the number of Members enrolled in WIC.

ii. The data exchange process must consider how to facilitate the provision of the following information from MCP or its Network Providers: proof of pregnancy, height and weight of Infants at birth, pregnant individuals' pre-pregnancy height and weight, immunization history, wellness check information, social drivers of health information as agreed upon by the Parties, and any additional information agreed upon by the Parties.

iii. To the extent individual authorization is required, the Parties must obtain authorization to share and use information for the purposes contemplated in this MOU in a manner that complies with applicable laws and requirements.

c. Interoperability. MCP must make available to Members their electronic health information held by MCP pursuant to 42 Code of Federal Regulations Section 438.10 and in accordance with APL 22-026 or any subsequent version of the APL. MCP must make available an application program interface that makes complete and accurate Network Provider directory information available through a public-facing digital endpoint on MCP's website pursuant to 42 Code of Federal Regulations Sections 438.242(b) and 438.10(h).

12. Dispute Resolution.

a. The Parties must agree to dispute resolution procedures such that in the event of any dispute or difference of opinion regarding the Party responsible for service coverage arising out of or relating to this MOU, the Parties must attempt, in good faith, to promptly resolve the dispute mutually between themselves. MCP must, and Agency should, document the agreed-upon dispute resolution procedures in policies and procedures. Pending resolution of any such dispute, the Parties must continue without delay to carry out all their responsibilities under this MOU, including providing Members with access to services under this MOU, unless this MOU is terminated.

b. Disputes between MCP and Agency that cannot be resolved in a good faith attempt between the Parties within 30 Working Days of initiating such dispute must be forwarded by MCP to DHCS and may be forwarded by Agency to DHCS. Until the dispute is resolved, the Parties may agree to an arrangement satisfactory to both Parties regarding how the services under dispute will be provided.

c. Nothing in this MOU or provision constitutes a waiver of any of the government claim filing requirements set forth in Title I, Division 3.6, of the California Government Code or as otherwise set forth in local, State, or federal law.

13. Equal Treatment.

a. Pursuant to 7 Code of Federal Regulations Section 246.3(b) and Title VI, 42 United States Code Section 2000d et seq., Agency cannot provide any service, financial aid, or other benefit to an individual that is different, or is provided in a different manner, from that provided to others under the WIC Program. Nothing in this MOU is intended to benefit or prioritize Members over WIC Participants who are not Members.

b. Agency is prohibited from directing or recommending that an individual choose or refrain from choosing a specific MCP, and MCP is prohibited from directing or recommending that an individual choose or refrain from choosing a specific agency that provides WIC Services.

c. Agency is prohibited from making decisions intended to benefit or disadvantage a specific MCP, and MCP is prohibited from making decisions intended to benefit or disadvantage a specific agency that provides WIC Services.

14. General.

a. MOU Posting. MCP must post this executed MOU on its website.

b. Documentation Requirements. MCP must retain all documents demonstrating compliance with this MOU for at least 10 years as required by the Medi-Cal Managed Care Contract. If DHCS requests a review of any existing MOU, MCP must submit the requested MOU to DHCS within 10 Working Days of receipt of the request.

Notice. Any notice required or desired to be given pursuant to or in connection with this MOU must be given in writing, addressed to the noticed Party at the Notice Address set forth below the signature lines of this MOU. Notices must be (i) delivered in person to the Notice Address; (ii) delivered by messenger or overnight delivery service to the Notice Address; (iii) sent by regular United States mail, certified, return receipt requested, postage prepaid, to the Notice Address; or (iv) sent by email, with a copy sent by regular United States mail to the Notice Address. Notices given by in-person delivery, messenger, or overnight delivery service are deemed given upon actual delivery at the Notice Address. Notices given by email are deemed given the day following the day the email was sent. Notices given by regular United States mail, certified, return receipt requested, postage prepaid, are deemed given on the date of delivery indicated on the return receipt. The Parties may change their addresses for purposes of receiving notice hereunder by giving notice of such change to each other in the manner provided for herein.

c. Delegation. MCP may delegate its obligations under this MOU to a Fully Delegated Subcontractor or Partially Delegated Subcontractor as

permitted under the Medi-Cal Managed Care Contract, provided that such Fully Delegated Subcontractor or Partially Delegated Subcontractor is made a Party to this MOU. Further, MCP may enter into Subcontractor Agreements or Downstream Subcontractor Agreements that relate directly or indirectly to the performance of MCP's obligations under this MOU. Agency may delegate its obligations under this MOU only to the extent permitted by applicable law and the local agency agreement with CDPH. Other than in these circumstances, the Parties cannot delegate the obligations and duties contained in this MOU.

d. Annual Review. MCP must conduct an annual review of this MOU to determine whether any modifications, amendments, updates, or renewals of responsibilities and obligations outlined within are required. MCP must provide DHCS evidence of the annual review of this MOU as well as copies of any MOU modified or renewed as a result.

e. Amendment. This MOU may only be amended or modified by the Parties through a writing executed by the Parties. However, this MOU is deemed automatically amended or modified to incorporate any provisions amended or modified in the Medi-Cal Managed Care Contract, amended or modified in Agency's local agency agreement with CDPH, or as required by applicable law or any applicable guidance issued by a State or federal oversight entity.

f. Governance. This MOU is governed by and construed in accordance with the laws of the State of California.

g. Independent Contractors. No provision of this MOU is intended to create, nor is any provision deemed or construed to create, any relationship between Agency and MCP other than that of independent entities contracting with each other hereunder solely for the purpose of effecting the provisions of this MOU. Neither Agency nor MCP, nor any of their respective contractors, employees, agents, or

representatives, is construed to be the contractor, employee, agent, or representative of the other.

h. Counterpart Execution. This MOU may be executed in counterparts, signed electronically and sent via PDF, each of which is deemed an original, but all of which, when taken together, constitute one and the same instrument.

i. Superseding MOU. This MOU constitutes the final and entire agreement between the Parties and supersedes any and all prior oral or written agreements, negotiations, or understandings between the Parties that conflict with the provisions set forth in this MOU. It is expressly understood and agreed that any prior written or oral agreement between the Parties pertaining to the subject matter herein is hereby terminated by mutual agreement of the Parties.

(Remainder of page intentionally left blank)

Exhibit H

Data Elements

a. MCP and Agency must share the following data elements:

i. Member demographic information;
ii. Behavioral and physical health information;
iii. Diagnoses, progress notes, and assessments;
iv. Medications prescribed;
v. Laboratory results; and
vi. Known changes in condition that may adversely impact the Member's health and/or welfare and that are relevant to the services.

Exhibit I – California Children's Services (CCS) Whole Child Model Program

I. BACKGROUND

The California Children's Services (CCS) Program provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to children under age 21 with CCS eligible medical conditions. The CCS Program is administered as a partnership between the California Department of Health Care Services (DHCS), County health departments, Regional Health Authority (RHA), alternate health care service plan (AHCSP), and some County Organized Health Systems (COHS) plans. Health and Safety Code (H&S Code), Section 123800 et seq. is the enabling statute for the CCS Program. The explicit legislative intent of the CCS Program is to provide Medically Necessary services for CCS-eligible children. The statute also requires that DHCS and the County cooperate with local public or private agencies and providers of medical care to proactively identify and enroll CCS eligible children.

Senate Bill (SB) 586 (Chapter 625, Statutes of 2016) authorized DHCS to establish the Whole Child Model (WCM) for Medi-Cal eligible CCS children enrolled in a Managed Care Plan (MCP) that is a COHS or Regional Health Authority, within designated counties. WCM incorporates CCS covered services for certain Medi-Cal eligible CCS children into the applicable MCP Contract Additionally, under the WCM, responsibility for the CCS case management, care coordination, provider referral, and service authorization functions move from the County to the WCM MCP. Assembly Bill (AB) 2724 (Chapter 73, Statutes of 2022) added a new section to define an AHCSP and to authorize DHCS to enter into one or more comprehensive risk contracts with an AHCSP as a primary MCP in specified geographic areas effective January 1, 2024. AB 118 (Chapter 42, Statutes of 2023) authorizes the expansion of the WCM program for Medi-Cal eligible CCS children and youth enrolled in a MCP served by a COHS, AHCSP, or RHA, into 12 additional counties no sooner than January 1, 2025.

The medical conditions covered by the CCS Program are outlined and authorized in California Code of Regulations (CCR), title 22, sections 41401 - 41518.9. These regulations are further clarified by CCS Numbered Letters (NLs).

II. PURPOSE

The purpose of this Memorandum of Understanding (MOU) between **Sonoma County** (County) and _____ (MCP) ("Parties", collectively) is to identify each party's responsibilities and obligations to each other in

accordance with and based on H&S Code section 123800 et seq., statutory requirements related to administration of the CCS Program by local county programs, the MCP's respective contract with DHCS, and all other applicable authorities. This MOU outlines the respective roles of the County and the MCP to coordinate care, conduct administrative activities, and engage in information exchange activities required for the effective and seamless delivery of CCS services to CCS eligible Members. This MOU is a binding contractual agreement.

The County and/or DHCS will retain all administrative responsibilities of case management, care coordination, provider referral, and service authorization functions of the CCS Program as it pertains to CCS State-only Members or Members that are currently in Fee for Service Medi-Cal.

III. TERM

This MOU is in effect as of the date of execution and shall automatically renew annually, unless written notice of non-renewal is given. MCPs must submit all fully executed MOUs to their Managed Care Operations Division (MCOD) Contract Manager for file and use. In their submissions, MCPs must attest that they did not modify any of the provisions of this MOU Template except to add provisions that do not conflict with or reduce either party's obligations under this MOU Templates. If the MCP or County modifies any of the provisions of the MOU Template, the MCP must submit a redlined version of the MOU to DHCS for review and approval, prior to execution. If the MOU is not modified, the fully executed MOU needs to be submitted to the MCOD Contract Manager for file only. The template includes language that the parties may want to add, notated in italics, to their MOUs to increase collaboration and communications; the proposed language is not exhaustive.

The Parties must review the MOU annually thereafter to determine whether any modifications, amendments, updates, or renewals of responsibilities and obligations outlined within are required. The MCP must provide evidence to DHCS of the annual review of MOU as well as copies of any MOU modified or renewed as a result. The evidence of the annual review described in the annual report must include a summary of the review process and outcomes, and any resulting amendments to the MOU or existing policies and procedures.

IV. CONFIDENTIALITY

All responsibilities and information shared by the County and the MCP in the provision of services for CCS eligible Members and under this MOU, must adhere to all applicable Federal, State and/or local laws and regulations relating to confidentiality. The Parties shall ensure compliance with all applicable privacy and security provisions, including Welfare &

Institutions Code §14100.2 and federal, state, and DHCS breach notification protocols.

V. LIABILITY AND INDEMNITY

County and the MCP are not liable to third parties for any act or omission of the other party. Each party is solely liable for any negligent or wrongful acts or omissions of its own officers, agents, and employees occurring in the performance of this MOU. If either the County or the MCP becomes liable for damages caused by its officers, agents or employees, it must pay such damages without contribution by the other and hold harmless the other from all costs and expenses resulting from any attorney fees and court costs, claims, losses, damages, and liabilities.

VI. RECORDS, AUDITS AND INSPECTIONS

County and the MCP must at any time, upon reasonable notice during business hours and as necessary, make all of its records and data with respect to the matters covered by this MOU and the CCS Program available for examination by Local, State, or Federal authorities, pursuant to applicable State or Federal statute or regulation. The MCP must retain all documents demonstrating compliance with this MOU for at least ten (10) years. The MCP must post this executed MOU on its website. The counties may post this executed MOU on its website.

VII. SCOPE OF RESPONSIBILITIES

The table below identifies the roles and responsibilities of each party as they relate to providing CCS services to CCS Eligible Members, including Eligibility and Enrollment services, Case Management services, Intercounty Transfers (ICT), CCS Advisory Committees, Continuity of Care, Data and Information Sharing, Emergency Preparedness, Dispute Resolution, Neonatal Intensive Care Unit (NICU) services, Quality Assurance and Monitoring, and Subcontractors. Not all CCS applicable regulations or other requirements are listed in the table below.

CCS Eligible Member Eligibility and Enrollment (Case Identification and Referral)	
MCP	**County**
The MCP must provide necessary documentation, including but not limited to medical records/case notes/reports pertaining to the CCS-eligible condition, to the County to assist with initial and annual medical eligibility determinations.	Independent counties are responsible for medical, financial, and residential eligibility determinations for referred CCS members, including determining initial medical eligibility determinations and redeterminations.

CCS Eligible Member Eligibility and Enrollment (Case Identification and Referral)	
MCP	**County**
The MCP must refer a Member to the County for a CCS eligibility determination if the Member demonstrates a potential CCS condition(s) as outlined in the CCS Medical Eligibility Guide, which may be amended. The MCP must include supporting documentation of the Member's potential CCS-eligible condition in all of its CCS referrals to the County. MCPs will be responsible for conducting the CCS NICU eligibility criteria assessment, authorization, and payment. Upon notification from the County, the MCP must obtain and provide to the county any additional information the County requires, such as medical reports pertaining to the CCS-eligible condition, to make a CCS Program eligibility determination. Within 90 days of its referral to the County, the MCP must inform the CCS eligible Member and their family (or designated legal caregiver) about the availability of medical care related to the CCS eligible condition. MCP must provide training and orientation for its employees, Network Providers, Subcontractors, and Downstream Subcontractors who carry out responsibilities under this MOU. The training must include information on MOU requirements, what services are provided or arranged for by each Party, and the policies and procedures outlined in this MOU. The MCP must provide the training prior to any such person or entity performing responsibilities under this MOU, and at least annually thereafter. The MCP must require its Subcontractors	Dependent counties are responsible for determining financial and residential eligibility. DHCS is responsible for determining medical eligibility for new referrals and annual redeterminations; except for NICU and High-Risk Infant Follow-Up (HRIF) eligibility determinations. The County must inform the child (Member under age 21) and their family (or designated legal caregiver) of the CCS Program eligibility determination. The County must inform the child determined to be ineligible and their family (or designated legal caregiver) of the CCS Program eligibility appeal process. The County must communicate to the MCP the CCS Program eligibility determination. The County must request any additional information required, such as medical reports, from the MCP to make a program eligibility determination. The County must provide notification to the MCP when the county becomes aware the member has moved out of the county. The County must proactively engage in a collaborative process with the MCP to remedy any issues or challenges related to timeliness or completeness of records for the medical eligibility redetermination process. The County must request medical records from the MCP for the annual medical

CCS Eligible Member Eligibility and Enrollment (Case Identification and Referral)	
MCP	**County**
and Downstream Subcontractors to provide training on relevant MOU requirements and the County's programs and services to its Network Providers. The MCP must provide educational materials to its Members and Network Providers related to accessing Medically Necessary Services, including materials provided by the County. The MCP must provide County with training and/or educational materials on how MCP Covered Services may be accessed, including during nonbusiness hours. The MCP must provide medical records to the County for the annual medical review (AMR) of CCS Program eligibility, including the most current medical records that document the CCS-eligible Member's medical history; the results of a physical examination by a physician; and laboratory test results, radiologic findings, or other tests or examinations that support the diagnosis of the eligible condition(s). The MCP's documentation must be dated within six months before the Member's program eligibility end date, to the extent possible, but no later than 12 months before the Member's program eligibility end date. The MCP must provide the documentation set forth above to the County 60 calendar days before the Member's program eligibility end date. If documentation is received by the County outside of the agreed upon timeframe, the MCP and County must collaborate to determine the best approach and time frame for submitting the required	review three months in advance of the member's program eligibility end date. The County must notify the MCP when the County becomes aware that a CCS-Eligible Member has lost Medi-Cal eligibility. By January 1, 2025, or date otherwise determined by DCHS, the County must collaborate with the MCP to develop a process to implement DHCS guidance regarding Closed Loop Referrals to applicable CCS benefits, and/or community-based resources, as referenced in the CalAIM Population Health Policy Guide, County CCS Program and MCP coordination requirements referenced in Numbered Letter (NL) 03-0421, or any superseding NLs, and the California Children's Services Program Administrative Case Management Manual, as amended from time to time, and as set forth by DHCS through NLs, or other guidance. The Parties must work collaboratively to develop and implement a process to ensure that the County and MCP comply with the applicable provisions of Closed Loop Referrals guidance within 90 days of the issuance of this guidance. The Parties must establish a system that tracks cross-system referrals and meets all requirements as set forth by DHCS through an NL or other guidance.

CCS Eligible Member Eligibility and Enrollment (Case Identification and Referral)	
MCP	**County**
documentation. If appointments occur within the 60-calendar-day period prior to the Member's program eligibility end date, the MCP and County must have procedures in place to ensure all appropriate most recent medical records that document the Member's medical history, results of a physical examination by a physician or an advanced practiced provider acting within the scope of their licensing authority, laboratory test results, radiologic findings, or other tests or examinations that support the diagnosis of the eligible condition(s), including any Medical Therapy Program (MTP) diagnosis are submitted to support AMR. If the County requires additional documentation, the MCP must, upon notification from the County, coordinate with the Member's provider(s) to obtain documentation, before the Member's CCS Program eligibility end date. The MCP must have procedures in place regarding outreach attempts to providers and the CCS member to obtain medical records, as well as appropriate actions to take if the MCP's efforts to obtain medical records are unsuccessful. The MCP must provide notification and necessary documentation to the County to assist with transition from MCP to CCS-State Only. The MCP must notify the County when the MCP becomes aware that a CCS eligible Member has lost Medi-Cal eligibility. The MCP must proactively engage in a collaborative process with the County to remedy any issues or challenges related to timeliness or completeness of records for the medical eligibility redetermination process.	

CCS Eligible Member Eligibility and Enrollment (Case Identification and Referral)	
MCP	**County**
By January 1, 2025, or date otherwise determined by DCHS, the MCP must collaborate with the County to develop a process to implement DHCS guidance regarding Closed Loop Referrals to applicable CCS benefits, and/or community-based resources, as referenced in the CalAIM Population Health Policy Guide,[1] All Plan Letter (APL) 22-024 or any superseding APLs, and the DHCS MCP Contract, as amended from time to time, and as set forth by DHCS through APLs, or other guidance. The Parties must work collaboratively to develop and implement a process to ensure that the MCP and County comply with the applicable provisions of Closed Loop Referrals guidance within 90 days of the issuance of this guidance. The Parties must establish a system that tracks cross-system referrals and meets all requirements as set forth by DHCS through an APL or other guidance.	

[1] The CalAIM Population Health Management Policy Guide is available at: https://www.dhcs.ca.gov/CalAIM/Documents/PHM-Policy-Guide.pdf.

Case Management (Care Coordination)	
MCP	**County**
The MCP must refer Members to the County if these Members are suspected of having an MTP-eligible condition and must include all supporting documentation with the referral. As a part of the CCS eligibility review, the County will review and determine MTP eligibility, if applicable. MCP must ensure that a CCS-eligible child has a primary point of contact who shall be responsible for the child's care coordination. The MCP must coordinate with the local CCS Medical Therapy Unit (MTU) to ensure appropriate access to MTP services. The MCP must consult with county MTP to coordinate durable medical equipment (DME) equipment needs of MTP eligible clients, as necessary. The MCP must not duplicate therapy services rendered by an MTP. The MCP must notify the County of CCS eligible neonates, infants, and children up to three years of age that lose Medi-Cal coverage for HRIF services. The MCP must regularly communicate and share relevant information via telephone and/or case management notes, written or electronic, with the County to facilitate the care of CCS Members who require services from both the County and the MCP. Communication may be via telephone, written, electronic case management notes, or secure email.	The CCS County Administrator or designee must coordinate with the MCP liaison or the MCP Utilization Management Director regarding member enrollment, as often as necessary. The County must submit referrals to the MCP for medically necessary specialty services and follow-up treatment, as prescribed by the County's Medical Therapy Conference (MTC) team physician. The County MTP is responsible for the provision of medically necessary occupational and physical therapy services prescribed by the County CCS MTU Conference Team Physician or the CCS-paneled physician who is providing the medical direction for occupational and physical therapy services. Upon notification from the MCP of a CCS Member that has lost MCP coverage, the County must ensure the coordination of HRIF outpatient diagnostic services. The County must regularly communicate, share relevant information via telephone and/or case management notes, written or electronic, with the MCP to facilitate the care of CCS WCM Members who require MTP services. Communication may be via telephone, written, electronic case management notes, or secure email. The County must identify staff who will meet quarterly and more often as necessary with the appointed MCP Liaison(s).

Case Management (Care Coordination)	
MCP	**County**
The MCP must provide CCS Maintenance and Transportation (M&T) and Non-Medical Transportation (NMT) for all Medically Necessary Covered Services, including services provided through the CCS Program and MTP, and coordinate Non-Emergency Medical Transportation (NEMT). The MCP must ensure reimbursements for M&T expenses are available to the CCS-eligible Member or their family in accordance with CCS NL 03-0810 and APL 21-005 or any superseding version of this NL and APL. The MCP must provide and authorize the CCS M&T benefit for CCS eligible Members or the Member's family seeking transportation to a medical service related to their CCS eligible condition(s) when the cost of M&T presents a barrier to accessing authorized CCS services. The MCP must authorize services based on medical necessity and/or evidence-based guidelines, including DME, consistent with CCS Program standards. The MCP must ensure all services related to the Member's CCS-eligible condition are provided by either CCS-paneled providers, CCS-approved Special Care Centers (SCCs), and/or CCS-approved pediatric acute care hospitals. The MCP must provide case management services for CCS-eligible conditions, to coordinate benefits, and to authorize services according to state regulations and APL 21-005 or any superseding APL. The MCP must inform CCS-eligible Members of the availability of the CCS Program and benefits as needed.	

Case Management (Care Coordination)	
MCP	**County**
The MCP must authorize a CCS-paneled provider or center to treat and manage the CCS-eligible condition. The MCP must, as part of its provider education strategy, educate Network Providers about the local CCS Program and the ways that the Primary Care Physician (PCP) can assist with integration of CCS-authorized services. The MCP must ensure that CCS-eligible Members receive all Medically Necessary pediatric preventive services, including immunizations, unless determined to be medically contraindicated. MCP must authorize, refer, and coordinate the delivery of Organ and Bone Marrow Transplant benefits and all Medically Necessary Covered Services associated with a transplant service. MCP must ensure that organ and bone marrow transplants services are provided to the Member at a CCS-approved SCC that has current CCS approval to transplant the specified organ in the Member's age group in accordance with Attachment 2 of APL 21-015 or any superseding APL. The MCP must conduct a HRIF program acuity assessment and authorize any HRIF services for the Member in accordance with the HRIF Eligibility Criteria.	

Case Management (Care Coordination)	
MCP	**County**
The MCP must ensure access or arrange for the provision of HRIF case management services. The MCP must notify the County of any CCS-eligible neonates, infants, and children up to three years of age that have been identified as having a potential CCS-eligible condition through the HRIF program. The MCP must accompany any referral to the County with supporting documentation of the Member's potential CCS-eligible condition. The MCP must develop and implement policies and procedures (P&Ps) that specify coordination activities and communication requirements among PCPs, specialty providers, hospitals, and the assigned case manager(s). The MCP must ensure that CCS-eligible Members and their families have ongoing information, education, and support regarding: • How to request continuity of care for pharmacy, specialized DME, and health care providers; • How to request M&T services; • How to request assistance with the transition to adult care; • Referrals to community resources; • The child's and family's role in the individual care process; • The availability of mental health services; and • Any other services that might be available (i.e. Regional Centers and Home and Community Based Alternatives Waiver Agencies)	

Case Management (Care Coordination)	
MCP	**County**
The MCP must determine which staff will be appropriate to meet, at a minimum quarterly, and as often as necessary, and maintain communication with the appointed CCS Liaison(s).	

Intercounty Transfer (ICT)	
MCP	**County**
The MCP must complete its ICT form and provide the County with the following documentation no later than ten (10 Working Days when requested by the County for a CCS-eligible Member's ICT: • Copies of current physical medical reports since the most recent annual medical redetermination. The MCP is not required to send reports from MTCs. • A list of the Member's authorized providers from at least the previous 12 months. • A list of the Member's authorized services from at least the previous 12 months. • Any information that will assist the receiving county of residence or receiving MCP in making authorization decisions.	During an ICT, the County must forward to a Member's new county of residence a completed ICT form and any documentation that the County received from the MCP. When the Member in the Sending County is enrolled in a WCM MCP, the Sending County must request the most recent medical reports, case management notes, and utilization information from the WCM MCP. The Receiving County is encouraged to collaborate with the MCP during their negotiations of a transfer date with the Sending County. For further guidance on ICTs, refer to the CCS Intercounty Transfer NL 09-1215. County must follow CCS Intercounty Transfer Policy NL 09-1215 or any superseding version of this NL.

Intercounty Transfer (ICT)	
MCP	**County**
• Case management notes related to the CCS-eligible medical condition, if possible. If that is not possible, the MCP must provide a summary note of relevant case management activities. During an ICT, the MCP must continue to provide case management services and make determinations as to Medically Necessary service authorization requests until the Member's transfer date. The MCP must coordinate with the County regarding the ICT date. The MCP must authorize Out-of-Network requests if the Member requires services in their new county of residence prior to the transfer date. During an ICT, the MCP must close all service authorization requests at least the day before the transfer date. The MCP must follow CCS ICT guidance in accordance with CCS Intercounty Transfer NL 09-1215 or any superseding NL.	

CCS Advisory Committees (Clinical Advisory and Family Advisory)	
MCP	**County**
The MCP must create and maintain a Clinical Advisory Committee composed of: • The MCP's medical director or the equivalent; • The County's CCS administrator, medical director or designee;	The following County representatives must actively participate in the MCP's Clinical Advisory Committee: • The County's CCS administrator, medical director or designee; or • The County's CCS Liaison

CCS Advisory Committees (Clinical Advisory and Family Advisory)	
MCP	**County**
• At least four CCS-paneled providers; and • The County's CCS Liaison(s) The Clinical Advisory Committee must meet at least quarterly or more frequently if determined to be necessary. The MCP's Family Advisory Committee (FAC) must ensure meaningful engagement of its members, which must include: • The County's CCS Liaison(s) and • The County's CCS representative(s) • CCS provider representatives. The MCP must coordinate with the County's CCS staff, local CCS providers, and consumer advocates to recruit CCS families for the FAC. The MCP must coordinate with CCS families to ensure they understand the FAC's role and their role as members of the FAC. The MCP may provide a reasonable per diem payment to enable in-person participation in the advisory committee. The MCP may utilize teleconference or other similar electronic means to facilitate participation.	The County's representatives will actively participate by: • Attending meetings • Engaging in discussion • Offering feedback and recommendations. The County must collaborate with the MCP to ensure meaningful engagement with family members. The County must coordinate with the MCP, local CCS providers, and consumer advocates to assist in recruiting CCS families for the FAC. The County must coordinate with CCS families to ensure they understand the FAC's role and their role as members of the FAC.

A. Continuity of Care	
MCP	**County**
Upon transitioning to WCM: If requested by the CCS-eligible Member within 90 days of the transition of their CCS services to the MCP, the MCP must ensure that the CCS-eligible Member continues to receive case management and care coordination from their public health nurse (PHN), if the PHN is available and the County and MCP reach a mutually agreeable financial arrangement. The MCP must establish and maintain a process by which a CCS-eligible Member may maintain access to navigating a health plan; maintain rights to appeal any service denials; and request continuity of care for pharmacy, health care providers, and specialized or customized DME providers for up to 12 months. The MCP must ensure that CCS families have ongoing information, education, and support regarding the rights to appeal any service denials, including the right to appeal a denial of Continuity of Care (COC) beyond 12 months, in accordance with APL 21-005, APL 22-032 or any superseding APLs. The MCP must attempt to enter into a Letter of Agreement (LOA) with the provider to allow for COC for at least one year if the child has established care with a provider prior to WCM and if that provider is not contracted with the MCP.	Upon transitioning to WCM: The County must respond to the MCP within 2 Working Days regarding the CCS-eligible Member's request to continue working with their PHN. In the event that the requested PHN is no longer available, the County must provide notice to the MCP of the PHN's last day in the CCS Program. If the County does not want to proceed with discussions, the County must submit a written notification to DHCS and the MCP on county letterhead to advise on the decision. The County must provide information on active CCS-eligible Member cases to the MCP unless a case has already been transitioned. The County is primarily responsible for providing case management to arrange all approved Private Duty Nursing (PDN) service hours if the County approves the PDN services for a CCS-eligible Member under the age of 21.[2] Existing WCM Counties must coordinate COC services with the MCP to the extent possible to ensure no delays of services to Members. The County must follow Continuity of Care guidance in accordance with H&S Code Section 123850(b).

[2] *Applicable during the transition period.*

A. Continuity of Care	
MCP	**County**
The MCP is primarily responsible for providing case management to arrange all approved PDN service hours if the MCP approves the PDN services for a Medi-Cal eligible CCS Member under the age of 21. If CCS has authorized PDN services and is primarily responsible for providing case management for those PDN services, MCPs must still provide case management as necessary, including, at the Member's request, arranging for all approved PDN services as required by APL 20-012 or any superseding APL.	

Data and Information Sharing (HIPAA/Medical Records Sharing)	
MCP	**County**
The MCP must ensure that appropriate staff has access to the Children's Medical Services Provider Electronic Data Interchange (PEDI) to view the status of CCS-Eligible Member data. The MCP must, in collaboration with the County, implement policies and procedures to ensure that the minimum necessary Member information and data for accomplishing the goals of this MOU are exchanged timely and maintained securely and confidentially and in compliance with the requirements set below. The MCP and County must share information in compliance with applicable law, which may include the Health Insurance Portability and Accountability Act and its implanting regulations, as amended ("HIPAA"), 42 Code of Federal Regulations (CFR) Part 2, and other State and federal privacy laws. The MCP must attach these P&Ps to this MOU within 90 calendar days of execution of	The County must ensure any Providers that create, receive, maintain, or transmit protected health information on behalf of the County agree to the same privacy restrictions, conditions, and requirements that apply to the County. The County must ensure any Subcontractors that create, receive, maintain, or transmit protected health information on behalf of the County CCS Program agree to the same restrictions, conditions, and requirements that apply to the County. The County must, in collaboration with MCP, implement policies and procedures to ensure that the minimum necessary Member information and data for accomplishing the goals of this MOU and are exchanged timely and maintained securely and confidentially and in compliance with the requirements set below. The MCP and County must share information in compliance with applicable

Data and Information Sharing (HIPAA/Medical Records Sharing)	
MCP	**County**
this MOU.	law, which may include HIPAA and its implanting regulations, as amended, 42 CFR Part 2, and other State and federal privacy laws. These policies and procedures must be attached to this MOU within 90-calendar days of execution.

Dispute Resolution	
MCP	**County**
If there is a dispute between the MCP and the County, all parties are responsible for carrying out all their responsibilities under the MOU without delay, including providing Members with access to services under the MOU.	If there is a dispute between the County and the MCP, all parties are responsible for carrying out all their responsibilities under the MOU without delay, including providing Members with access to services under the MOU.
The MCP must designate appropriate staff to participate in dispute resolution with the County. The MCP must meet at least quarterly with the County's CCS liaison(s) and the County's staff regarding operational and administrative issues. The MCP must respond timely to the County's dispute resolution requests. Disputes between the MCP and the County regarding CCS medical eligibility determinations that cannot be reached by mutual agreement in a good faith attempt between the MCP and the County must be forwarded by either party to DHCS via email to CCSRedesign@dhcs.ca.gov for review and a final determination.	The County must designate appropriate staff to participate in dispute resolution with the MCP. The County must meet at least quarterly with the MCP's Program/liaison staff regarding operational and administrative issues. The County must communicate all resolved disputes in writing to the MCP. Disputes between the County and the MCP regarding CCS medical eligibility determinations that cannot be resolved in a good faith attempt between the MCP and the County must be forwarded by either party to DHCS via email to CCSRedesign@dhcs.ca.gov for review and a final determination.

Neonatal Intensive Care Unit (NICU)	
MCP	**County**
The MCP must conduct assessments in accordance with CCS Program guidelines for medical eligibility for care in a CCS-approved NICU, as found in CCS NL 05-0502 or any superseding NL. In order to capture the CCS referral, the MCP must report to the County's CCS Program all Members identified as meeting the criteria for the NICU eligibility assessment. The MCP must accompany any CCS referral to the County with supporting documentation of the Member's potential CCS eligible condition.	The County must review all cases for CCS Program determinations referred to the County by an MCP when a Member may have any newly identified or potential CCS-eligible conditions, including infants with a potential CCS-eligible condition at time of discharge from the NICU, as well as infants and children undergoing diagnostic evaluation for CCS-eligible conditions.

Quality Assurance and Monitoring	
MCP	**County**
MCP must collaborate with the County to establish policies and procedures for oversight of all of the requirements of this MOU, including, without limitation, requirements related to combined Quality Improvement (QI) activities, including, but not limited to, any applicable performance measures and QI initiatives as well as reports that track cross-system referrals, CCS eligible Member engagement, and service utilization and to prevent duplication of services rendered. The MCP must participate in meetings with the County at least quarterly to update P&Ps and protocols as appropriate. The MCP and the County may establish frequency of meetings. • All documentation related to these meetings should be made available to DHCS for auditing purposes, including agendas and sign-in sheets. Meeting facilitation is determined by the MCP and the County. The MCP's CCS liaison must report to the MCP's Compliance Officer on the MCP's compliance with the MOU no less frequently than quarterly.	The County must collaborate with the MCP to establish policies and procedures for oversight of all of the requirements of this MOU, including, without limitation, requirements related to QI activities, including, but not limited to, any applicable performance measures and QI initiatives as well as reports that track cross-system referrals, CCS eligible Member engagement, and service utilization and to prevent duplication of services rendered. Meeting facilitation is determined by the County and MCP.

Subcontractors	
MCP	**County**
The MCP must ensure that all of its Subcontractors comply with all California Welfare and Institutions Code (W&I Code) section 123850 requirements that apply to the MCP.	The County must ensure that all of its Subcontractors comply with all California W&I Code section 123850 requirements that apply to the County.

VIII. AMENDMENTS

The County and the MCP may amend this MOU at any time by written, mutual consent. The County and the MCP must submit any amended MOUs to DHCS and receive DHCS' final review and approval before execution of the amended MOU.

IX. LIAISONS

The MCP must designate an individual or set of individuals as part of its Provider Relations/Community Relations or related functions to serve as the liaison for CCS county administrators and providers, including CCS specialty care center providers.

The County and the MCP must designate CCS liaisons to be the primary points of contact for this MOU. The CCS liaisons must meet no less than quarterly to discuss activities related to this MOU and any other related matters. The County and the MCP must also submit the contact information for their respective liaisons to DHCS.

For the purposes of this MOU, the primary liaison for the MCP is the KP CCS Coordinator and the primary liaison for the County is the Medical Therapy Unit Manager and CCS Supervising PHN or delegate as specified by the County Director.

X. DATA AND INFORMATION SHARING AGREEMENT(S)

The purpose of this section is to ensure protection of any data or information sharing related to the WCM and to comply with the Health Insurance Portability and Accountability Act and any other applicable privacy requirements.