ATTACHMENT F: LOCAL HEALTH DEPARTMENT MEMORANDUM OF UNDERSTANDING TEMPLATE

COVER PAGE

Memorandum of Understanding

between [*Medi-Cal Managed Care Plan*] and [*Local Health Department*]

This Memorandum of Understanding ("MOU") is entered into by [*name of Managed Care Plan*] ("MCP**"**) and [*name of Local Health Department*], a local health department ("LHD"), effective as of [*date*] ("Effective Date"). [*Where MCP has a Subcontractor or Downstream Subcontractor arrangement delegating part or all of the responsibilities related to effectuating this MOU to a Knox-Keene licensed health care service plan(s), this Subcontractor or Downstream Subcontractor must be added as an express party to this MOU and named in this MOU as having the responsibilities set forth herein that are applicable to this Subcontractor or Downstream Subcontractor.*] 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;

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.

[Notation: This MOU template includes language, notated in italics and bracketed, that the Parties may want to add to this MOU to increase collaboration and communication. MCP and LHD may also agree to additional provisions provided that they do not conflict with the requirements of this MOU.]

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 continues for a term of *[The Parties may agree to a term of three years or another term as agreed to by MCP and LHD.]* or as amended in accordance with 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 [insert title], 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 [insert title], 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.

[The Parties may agree to additional requirements such as:

- *The LHD Responsible Person must ensure there is sufficient staff at LHD who support compliance with and management of this MOU.*
- *LHD must develop and implement MOU compliance policies and procedures for LHD programs, including oversight reports and mechanisms to address barriers to care coordination.*
- *The LHD Responsible Person must ensure that training and education regarding MOU provisions are conducted annually for LHD employees, Subcontractors, Downstream Subcontractors, and Network Providers as applicable.*
- *The LHD Program Liaison(s) must meet MOU compliance requirements, as determined by policies and procedures established by LHD, and must report to the LHD Responsible Person.]*

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 *[The Parties may agree to 30, 45, or 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. *[The Parties may agree to make this requirement mutual.]*

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.

[The Parties may agree to additional requirements such as:

- *If MCP or LHD develops training and education resources covering the services provided or arranged by the Parties, then each Party must share its training and education resources with the other Party to ensure the information included in their respective training and education resources sets forth an accurate set of*

services provided or arranged for by each Party and is consistent with MCP and LHD policies and procedures, and with clinical practice standards.

- *The Parties must make information that describes MCP Covered Services and/or LHD services or programs under this MOU available to Members, LHD clients, and/or other individuals who may be eligible for these resources.*
- *MCP training materials shared with LHD must include billing and claims requirements for LHD reimbursement for non-contracted LHD services pursuant to Section 13.*
- *MCP must share LHD provider training and/or educational opportunities that MCP is aware of with Network Providers and practitioners.*
- *LHD must provide to the LHD Program Liaison(s) and LHD program providers training and educational materials on MCP's Covered Services, including non-emergency medical transportation ("NEMT") and non-medical transportation ("NMT"), to support LHD program providers in assisting Members with accessing MCP's Covered Services.]*

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.

[The Parties may agree to additional requirements such as:

***Closed Loop Referrals.** By January 1, 2025, 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.
        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.

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

[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

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.

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. *[The Parties may agree to meet more frequently.]* 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.

[The Parties may agree to additional requirements, such as a requirement that the Parties must adopt joint policies and procedures establishing and addressing QI activities for coordinating the care and delivery of services for Members.]

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.

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

[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

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).

[The Parties may agree to additional requirements such as:

Disaster and Emergency Preparedness. *The Parties must develop policies and procedures to mitigate the effects of natural, man-made, or war-caused disasters involving emergency situations and/or broad health care surge events greatly impacting the Parties' health care delivery system to ensure the continued coordination and delivery of LHD programs and services and MCP's Covered Services for impacted Members.]*

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 [*suggested:* 15 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.

(Remainder of this page intentionally left blank)

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:
Name:
Title:
Notice Address:

LHD Director or Responsible Person

Signature:
Name:
Title:
Notice Address:

[Subcontractor or Downstream Subcontractor]

Signature:
Name:
Title:
Notice Address:

[MCP, if multiple MCPs in County]

Signature:
Name:
Title:
Notice Address:

Exhibits A and B.

[Placeholder for Exhibits to contain MCP and LHD Program Liaisons as referenced in Sections 4.b and 5.b of this MOU]

Programs (e.g., California Children's Services)	Designated MCP Liaison	Designated LHD Program Liaison(s)

[Notation: The Parties should each list their designated Responsible Person(s) and liaison(s) by name and contact information in this Exhibit. For example, if LHD has different persons designated to act as the liaison for CCS and Blood Lead Screening, each should be listed in this Exhibit by name, contact information, and designated role.]

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.

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.

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.

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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

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 *[LHD/covered service area]* 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 TB clinic, when needed or applicable.

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.

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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.

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.

ii. 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.

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.

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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

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 *[and/or enrolling Members, as applicable in MCAH Programs]* within [*insert #*] Working Days of receiving a referral. *[LHD should provide a definitive time period. If the definitive time period differs per MCAH Program, LHD should include the time period for each program.]*

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.

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.

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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

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.

[The Parties may agree to additional requirements, such as that MCP and LHD may collaborate to collect feedback from Members in MCAH Programs on topics of interest to Parties through surveys, focus groups, or other agreed-upon methods, and in accordance with this MOU.]

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.

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[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

7. Data Information and Exchange.

[The Parties may agree to additional requirements such as:

- *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.]*

Exhibit F. California Children's Services.

This Exhibit F governs LHD's provision of the California Children's Services ("CCS") Program only to the extent that such services are provided by LHD. MCP and LHD will collaborate to coordinate care, conduct administrative activities, and exchange information required for the effective and seamless delivery of services to MCP's Members enrolled, or eligible to enroll, in the CCS Program. This Exhibit F does not apply to an LHD or MCP that operates the Whole Child Model ("WCM").

This Exhibit delineates the roles and responsibilities of MCP and LHD for coordinating care and ensuring the non-duplication of services for Members eligible for or enrolled in the CCS Program.

[This Exhibit includes in brackets provisions to be included for Dependent Counties – those with total populations under 200,000 persons that may administer the CCS Program independently or jointly with DHCS pursuant to Cal. Health & Safety Code Section 123850(a) – that set forth additional roles and responsibilities in such counties.]

1. **Party Obligations.**
    a. **MCP Obligations.**
        i. MCP must ensure all Medically Necessary Covered Services related to the CCS condition are provided until a determination of CCS Program eligibility is made. MCP must continue to provide all Medically Necessary Covered Services to the Member if the CCS Program determines the referred Member is not eligible for the CCS Program and for services not provided through the CCS Program.
        ii. MCP must provide all Medically Necessary Covered Services not authorized by the CCS Program for CCS-enrolled Members, including, without limitation, Medi-Cal for Kids and Teens (previously known as EPSDT) services, pediatric preventive services, and immunizations unless determined to be medically contraindicated in accordance with the Medi-Cal Managed Care Contract and APL 23-005.
        iii. It is MCP's responsibility to provide case management (arranging PDN hours) in accordance with APL 20-012 and any superseding APL or other, similar guidance.
        iv. MCP must provide to the CCS Program, in a timely manner, all medical utilization and other clinical data necessary for the CCS Program to complete annual medical determinations and redeterminations, as well as other medical determinations, as needed, for CCS-eligible Members.
    b. **LHD Obligations.**
        i. LHD must ensure that its CCS Program authorizes and provides medical case management services for the medical conditions outlined and authorized

in Cal. Code Regs. tit. 22 Sections 41410-41518.9 for Members who have CCS-covered conditions (referred to as "CCS-Eligible Condition(s)").[22]

ii. LHD is responsible for making all CCS Program medical, financial, and residential eligibility determinations for potential CCS-eligible Members, including responding to and tracking appeals relating to CCS Program eligibility determinations and annual redeterminations.

[**Replace 1.b.ii with the following for Dependent Counties:** DHCS is responsible for CCS Program medical eligibility determinations and redeterminations, and LHD's CCS Program is responsible for financial and residential eligibility determinations and redeterminations for potential CCS-eligible Members. Such medical eligibility determinations and redeterminations include eligibility determinations for (i) Medical Therapy Program ("MTP") services; (ii) High-Risk Infant Follow-up ("HRIF") Program services; and (iii) organ transplants and related services. DHCS may utilize the information shared by MCP to conduct medical determinations and redeterminations to determine the Member's eligibility for the CCS Program. To the extent that DHCS is responsible for conducting the eligibility determinations on behalf of the CCS Program in the dependent county, if DHCS determines a Member is eligible for CCS Program services, it will notify the CCS Program of such eligibility at which point LHD must ensure the CCS Program coordinates the Member's care and case management with MCP.]

2. Training and Education.

a. The training and education that MCP is required to provide under Section 6 of this MOU must include information about LHD's CCS Program, how to refer Members to the CCS Program, and how to assist Members with accessing CCS Program services.

b. The training MCP is required to provide under Section 6 of this MOU must include:

i. Instructions on how to complete the appropriate baseline health assessments and diagnostic evaluations, which provide sufficient clinical detail to establish or raise a reasonable suspicion that a Member has a CCS-Eligible Condition;

ii. Instructions on how to refer Members with a suspected CCS-Eligible Condition on the same day the evaluation is completed, using methods accepted by LHD (the initial referral must be followed by the submission of supporting medical documentation sufficient to allow for CCS Program eligibility determination by LHD);

iii. A statement that the CCS Program reimburses only CCS-paneled providers and CCS-approved hospitals;

[22] Covered conditions and regulations applicable to the CCS Program are described by CCS Numbered Letters ("NL") located on the CCS website, available at: https://www.dhcs.ca.gov/services/ccs/Pages/CCSNL.aspx

iv. A statement that the Network Provider must continue to provide all Medically Necessary Covered Services to the Member until the Member's CCS Program eligibility is confirmed;

v. Information on how to refer Members in LHD's CCS Program to community resources; and

vi. Information on how the PCP can assist with accessing CCS Program authorized services and can coordinate such services with other services Members may receive.

3. **Referrals and Eligibility Determinations.**

a. MCP Referrals. MCP is responsible for assisting Network Providers with identifying potentially CCS-eligible Members for whom there is diagnostic evidence that such Members have a CCS-Eligible Condition in accordance with Cal. Code Regs. tit. 22 Section 41515.1 and referring such Members to LHD to determine whether the Members are eligible for the CCS Program.

[**Add the following for Dependent Counties:** To the extent applicable in the dependent county, upon referring Members who may be CCS-eligible to the CCS Program, MCP must also submit Members' medical utilization information, clinical data, and any other necessary information, in the manner specified by DHCS, to CCSDirectedReview@dhcs.ca.gov to ensure DHCS has the requisite information to conduct the Member's medical eligibility determination.]

i. MCP must include with its Member referrals documentation of the Member's medical and residential information to enable LHD to make an eligibility determination for the CCS Program.

ii. MCP must refer, or assist Network Providers with referring, to LHD's CCS Program for CCS initial eligibility determinations a Member who:

1. Has a medical diagnosis, records, or history suggesting potential CCS-Eligible Condition(s) as outlined in the CCS medical eligibility regulations;
2. Presents at a hospital emergency room, a provider office, or another health care facility for a non-CCS condition, and for whom the medical evaluation identifies a potential CCS-Eligible Condition(s);
3. Is an infant with a potential CCS-Eligible Condition at the time of discharge from the neonatal intensive care unit (such Member must be assessed for eligibility and, if eligible, referred to the CCS Program's HRIF program); or
4. Has diagnostic evidence that the Member has a condition eligible for Medical Therapy Program services from the CCS Program's Medical Therapy Unit; or
5. May have a newly identified potential CCS-Eligible Condition(s) as determined by a Network Provider.[23]

[23] Additional information about the MTP is available at https://www.dhcs.ca.gov/services/ccs/Documents/CCS-NL-Whole-Child-Model-Revised.pdf

iii. In accordance with Chapter 1, Section 1.B of the California Children's Services Program Administrative Case Management Manual[24], LHD must ensure that within five calendar days from the receipt of a referral from MCP the CCS Program staff review the information provided and take one of the following actions:

1. Accept the referral as complete as defined in the CCS Program Administrative Case Management Manual Case Management Manual; or
2. Reject the referral as incomplete and forward a transmittal notice to MCP as required by the CCS Program Administrative Case Management Manual Case Management Manual.

b. LHD Eligibility Determination.

i. LHD must determine Members' medical, financial, and residential eligibility, initially and on an annual basis in accordance with Cal. Code Regs. tit. 22 Section 41515.1, for CCS-Eligible Conditions based on evaluation of documentation provided by MCP or by a CCS paneled provider.

[**Replace 3.b.i with the following for Dependent Counties**: LHD is responsible for conducting Members' financial and residential eligibility determinations. DHCS must determine Members' medical eligibility, initially and on an annual basis, for CCS-Eligible Condition(s) based on evaluation of documentation provided by MCP or by a CCS paneled provider. DHCS must notify LHD of Members who meet the medical eligibility criteria and must assist LHD with ensuring such Members are enrolled in its CCS Program.]

ii. LHD must assist its CCS Program with obtaining, and may request from MCP, any additional information required (e.g., medical reports) to determine CCS Program eligibility.

iii. LHD must ensure its CCS Program informs the Member and their family (or designated legal caregiver) of the CCS eligibility determination.

iv. LHD must create and send the Notice of Action ("NOA") to a Member who is determined to be ineligible for or is denied CCS Program services. Each NOA must notify the Member of their ineligibility in accordance with Cal. Code Regs. tit. 22 Sections 42131 and 42132 and must refer the Member back to MCP, which remains responsible for providing the Medically Necessary Covered Services to correct or ameliorate Members' physical conditions and/or mental illnesses. *[**Remove for Dependent Counties and add as a new section:** DHCS is responsible for creating a NOA for a Member who is denied services or is determined to be medically ineligible, and LHD is responsible for sending such NOA to a Member evaluated for its CCS Program.]*

[24] CCS Program Administrative Case Management Manual: Chapter One, available at https://www.dhcs.ca.gov/services/ccs/Documents/CCSAdminCaseManManual.pdf

v. If LHD receives a Member referral through an Inter-County Transfer, the CCS Program must complete applicable activities as set forth in the DHCS CCS Inter-county Transfer NL.

c. Enhanced Care Management Referrals.

i. The CCS Program should work with MCP to create a referral pathway for ECM for ECM-eligible Members.

ii. MCP must identify eligible Members for ECM through analysis of CCS Program enrollment and additional data available to MCPs, including utilizing Social Drivers of Health ("SDOH")-related ICD-10 Z-codes and identifying SDOH and high measures on adverse childhood experiences screenings.

iii. In cases where a Member is enrolled in the CCS Program and such CCS Program provider becomes a contracted ECM Provider, MCP must assign that Member to that CCS Program for ECM unless the Member or their parent, designated legal caregiver, or Authorized Representative prefers otherwise.

iv. If LHD's CCS Program is an ECM Provider, LHD's CCS Program must provide ECM services pursuant to that separate agreement between MCP and the CCS Program; this MOU does not govern the CCS Program's provision of ECM services.

4. Care Coordination and Collaboration.

a. Care Coordination.

i. MCP must coordinate with the CCS Program to ensure that Members enrolled in the CCS Program or eligible for CCS Program services receive all Medically Necessary Covered Services required for CCS-Eligible Condition(s) through the CCS Program and receive all Medically Necessary Covered Services that are not related to the CCS-Eligible Condition(s) through MCP.

ii. Until the Member's CCS eligibility is confirmed by the CCS Program **[or for Dependent Counties: DHCS]** and the CCS Program begins providing the Medically Necessary Covered Services for the CCS-Eligible Condition(s), MCP must continue to provide all Medically Necessary Covered Services for the CCS-Eligible Condition(s).

iii. Once the Member is enrolled in the CCS Program, the CCS Program is responsible for the Member's case management and care coordination for the CCS-Eligible Condition(s).

iv. MCP must develop and implement policies and procedures for coordination activities, joint case management, and communication requirements between the Member's PCP, specialty providers, hospitals, CCS providers, and CCS case manager(s).

v. MCP and LHD must have policies and procedures for coordination with LHD's CCS MTP to ensure appropriate access to MTP services and other services provided for the coordination of CCS Program services.

b. CCS HRIF Program. The CCS Program **[or for Dependent Counties: DHCS]** must coordinate and authorize HRIF services for eligible Members and must ensure access to, or arrange for the provision of, HRIF case management services.

c. PDN Case Management Responsibilities. MCP and LHD must coordinate the provision of case management services for Members who are receiving PDN services to ensure that Members receive case management services and that the Parties do not duplicate the services as set forth in APL 20-012, CCS NL 04-0520, and any superseding APL or other, similar guidance.[25]

i. If the CCS Program approves PDN services for CCS-eligible Members under the age of 21, the CCS Program is primarily responsible for providing case management to arrange for all approved PDN service hours to treat the CCS-Eligible Condition. When arranging for the CCS-eligible Members to receive authorized PDN services, the CCS Program must document all efforts to locate and collaborate with PDN service providers and MCP.

ii. If MCP approves PDN services for an eligible Member under the age of 21, MCP is primarily responsible for providing case management to arrange for the PDN service hours.

iii. MCP must, in collaboration with the CCS Program, continue to provide case management to Members receiving PDN authorized by the CCS Program, including, at the Member's request or the request of the Member's Authorized Representative, arranging for all approved PDN services.

d. Transportation Services.

i. CCS Maintenance and Transportation services related to CCS-Eligible Conditions are provided and covered by the CCS Program, as determined by the CCS Program and as resources allow, in accordance with Cal. Health & Safety Code Section 123840(j). MCP must communicate regularly with the CCS Program to ensure Members' needs are continuously met and must arrange for transportation for Members' Medi-Cal for Kids and Teens services when the Members' needs are not met in accordance with APL 22-008.

ii. Emergency Medical Transportation related to the CCS-Eligible Condition is the responsibility of the CCS Program.

iii. MCP must provide NEMT for all Medically Necessary Covered Services and pharmacy services, which may include services provided through the CCS Program, as outlined in the Medi-Cal Managed Care Contract and APL 22-008. MCP must refer and coordinate NEMT for services not covered under the Medi-Cal Managed Care Contract.

iv. **[For Independent Counties only]** MCP and the CCS Program must establish policies and procedures for determining whether NEMT is provided pursuant to a CCS-Eligible Condition(s) and when such services must be paid for by the CCS Program or MCP.

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[25] Additional information for PDN services is available in APL 20-012 at https://www.dhcs.ca.gov/services/Documents/APL-20-012.pdf.

v. If a Member requests NMT, MCP must authorize the NMT if necessary for the Member to obtain Medically Necessary Covered Services.

e. Emergency Services.

i. The CCS Program must coordinate with MCP for Members who need to be transferred to emergency services as set forth in NL10-0806 or any superseding NL, including:

1. Ensuring the CCS Program coordinates with the appropriate MCP-LHD Liaison confirm the suitable provision of emergency services related to trauma;
2. Requiring the CCS Program to notify the MCP-LHD Liaison as soon as possible of the need to transfer a CCS-eligible Member to the appropriate hospital; and
3. In the event families receive bills for services, contacting the provider to request they become a CCS-paneled provider and thus bill the CCS Program rather than the Member.

ii. The CCS Program must notify the MCP-LHD Liaison and DHCS if these efforts do not resolve the problem.

f. Continuity of Care for Transitioning Members.

i. MCP must maintain policies and procedures for identifying CCS-Eligible Members who are aging out of the CCS Program.

ii. MCP must follow the Continuity of Care requirements stated in APL 22-032 or any superseding APL.

iii. MCP must develop a care coordination plan to assist a Member with transitioning out of the CCS Program within 12 months prior to the Member's aging out, including:

1. Identifying the Member's CCS-Eligible Condition(s);
2. Planning for the needs of the Member to transition from the CCS Program;
3. Developing a communication plan with the Member in advance of the transition;
4. Identifying and coordinating primary care and specialty care providers appropriate for the Member's CCS-Eligible Condition(s); and
5. Continuing to assess the Member through the first 12 months after the Member's 21st birthday.

g. Major Organ Transplants.

i. To ensure the appropriate referral and care coordination for CCS-eligible or enrolled Members requiring a Major Organ Transplant ("MOT"), MCP and LHD must comply with guidance set forth in Blood, Tissue, and Solid Organ Transplants NL and APL 21-015 or any superseding NL and APL or other, similar guidance, and MCP must comply with the requirements set forth in the Medi-Cal Managed Care Contract.

ii. MCP will not be required to pay for costs associated with transplants that qualify as a CCS-Eligible Condition if MCP does not participate in the WCM program.

iii. MCP must refer CCS-eligible Members to a CCS-approved Special Care Center for an evaluation within 72 hours of the Member's PCP or specialist identifying the CCS-eligible Member as a potential candidate for a MOT.

iv. If the Member is not eligible for the CCS Program, MCP must authorize a MOT if Medically Necessary.

h. Quarterly Meetings.

i. MCP must invite LHD Responsible Person and the LHD Program Liaison(s) for the CCS Program to attend the quarterly meetings with LHD, to discuss any needed improvements and address barriers to care coordination or referral processes. Other LHD CCS Program representatives may be permitted to participate in quarterly meetings.

ii. The CCS Program must designate a medical director or other designee to actively participate in MCP's quarterly meetings with LHD. The CCS Program medical director or designee must attend meetings and provide feedback and recommendations on clinical issues relating to CCS conditions and treatment authorization guidelines and must serve as a clinical advisor on other clinical issues relating to CCS conditions.

5. Data Information and Exchange.

a. MCP must timely provide the following information to the CCS Program: the necessary documentation, medical records, case notes, medical utilization information, clinical data, and reports to enable the CCS Program to conduct the Member's initial residential and medical eligibility determination for the CCS Program and to provide services to the Member for treatment of their CCS-Eligible Condition.

b. Each of the Parties must notify the other Party upon learning that a Member has lost Medi-Cal eligibility.

Exhibit G.

[The Parties may agree to additional data elements, such as:

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.]*